STATE TITLE V BLOCK GRANT NARRATIVE
STATE: MS
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The MDH has a copy of the Assurances and Certifications on file. If you wish to review this file, please contact Ulysses Conley by email (uconley@msdh.state.ms.us) or phone at (601) 576-7688.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

The Mississippi Department of Health (MDH) solicits public input by making copies of the Block Grant Application available at each of the nine (9) public health district offices in the state to allow local citizens an opportunity to visit and view this document at their convenience. A copy of the 2006 Block Grant will also be placed on the agency's website (www.msdh.state.ms.us) to be viewed by citizens who have access to computers.

Public input will continue to be solicited through key parent and family support groups who are affiliated with programs funded by the grant.

Through the needs assessment year, public input was solicited in the form of surveying consumers, holding focus groups, and holding needs assessment conferences. Input was provided by professionals and consumers alike.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Mississippi is a predominately rural state with approximately three-quarters of the 2.8 million state residents living in non-metropolitan areas. On the south, it borders Louisiana and the Gulf of Mexico; its western border is the Mississippi River; to the north is Tennessee; and to the east is Alabama. Mississippi's 82 counties occupy 47,715 square miles. The racial composition of Mississippi residents is mixed, with three fifths of the residents white and about two fifths black. Mississippi has the largest proportion (nearly 40 percent) of black residents among all the states. The Hispanic and non-citizen immigrant populations are small but growing, as Cubans and Central Americans have been brought in to work for the poultry, forestry, and construction industries in the state. According to 2000 U.S. Census data, Hispanics comprise 1.4% of the state's population. Mississippi is, and has been for many years, one of the poorest states in the nation. According to the Kaiser Family Foundation's 2002-2003 State Health Facts, 31% of Mississippi's children aged 18 and under live at or below the federal poverty rate.

A substantial share of employment in Mississippi is agricultural work. Because national economic statistics do not adjust for the local cost of living, these statistics probably overstate the relative level of poverty in the state.

According to the "Mississippi Economic Review and Outlook" June 2005 report, employment in the state is expected to rise only about 1.2% during 2005. The expansion of the Nissan plant during 2004 has helped increase total manufacturing employment to 177,930 as of the first quarter of 2005. The greatest employment increase has occurred in the services industry by 1.5%. Construction employment increased by only 1.3%.

Tourism appears to have fallen victim to high gasoline prices. As of May 23, 2005, the average per gallon cost of gasoline was $2.12. Employment in Arts, entertainment and recreation has dropped by 5.6%. Employment in amusement and gaming has declined by 4.6% during 2004.

Fiscal problems continue to plague the state. State budget problems may result in considerable down-sizing and job loss for state agencies and shifting financial responsibilities for K-12 education to local government. During the period between FY 1994 and FY 2004, Mississippi's total bonded debt tripled in size climbing to $3.1 billion.

The fall of the MCI WorldCom telecommunications giant has contributed to a loss in jobs in the communications industry. Telecommunications employment in dropped by 6.4% during 2004.

While the economic outlook for Mississippi has become more positive in recent years, the state remains one of the poorest in the nation. Compared with the nation as a whole, a greater percentage of children in Mississippi are born out of wedlock and live in one-parent families. According to the 2004 Kids Count Data Book, Mississippi ranks 49th of the 50 states in births to females ages 15-17.

However, the 2004 immunization rate for two-year old children is one of the highest among the states at 87.8 percent, and is continually improving because of the development of a statewide immunization registry and outreach campaign. Other measures of child health and well-being are less encouraging. According to the recently released 2004 Kids Count Data Book, Mississippi has improved in 6 out of 10 measures that reflect child well-being between 1996 and 2001. Mississippi saw improvements in child well-being in the following areas: infant mortality rate by five percent; child death rate by 13 percent; teen birth rate by 24 percent; percent of children living in families where no parent has full-time, year-round employment by 6 percent; percent of children in poverty by 19 percent. According to this same source, Mississippi had one of the highest percentages of low birth-weight babies in 2001, the highest infant mortality and child death rates, and ranks number 48 in teen deaths by accidents, homicide, and suicide. Overall, Mississippi was ranked last among the states in a composite rating of 10 selected measures of child well-being.

Because of the high level of poverty, Mississippi faces challenges more severe than those of other states when it tries to craft policies to help low-income families. The state relies on a regressive tax system to generate revenues, with a high sales tax and a low income tax relative to national averages. It also relies heavily on federal funding sources to augment its budget.

Political power in Mississippi is distributed among a number of independent bodies. There is a sense of equitable, if not necessarily shared, influence over state functions between the Governor and the legislature. Much of this shared influence stems from the organization of state agencies, some of which fall under the Governor's purview and some of which are independent agencies. For example, the Mississippi Development Authority (MDA), the Division of Medicaid, and the Department of Human Services (DHS) are executive branch agencies, while the Mississippi Department of Health (MDH) is independent. Independent agencies are governed by boards whose members are appointed by the Governor. The Governor maintains indirect influence through these appointments, but independent agencies must deal more directly with the legislature in negotiating budgets and significant policy changes. With the mix of executive and independent agencies, state agency heads do not function together as a cabinet, a situation that results in a number of horizontal power bases within the state government structure. Economic factors continue to influence the Title V delivery system. Since the demise of Medicaid's mandatory managed care program (HealthMACS), an increase in the number of maternity patients seeking prenatal care at county health departments has not occurred; however, the number of maternity patients receiving Perinatal High Risk Management services has begun to increase. Local health departments also expect an increase in Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening and well-child services as well.

The State Legislature created a Child Health Insurance Task Force in 1998 to develop a State Plan for the implementation of a State Child Health Insurance Program (SCHIP), which began providing coverage in late 1998 to children aged 15 through 18 years of age whose family income was between 33 percent and 100 percent of the federal poverty level (Phase I). A state plan to extend coverage to all children between 100 percent and 200 percent of the federal poverty level was approved by the Centers for Medicare and Medicaid Services (CMMS) in February 1999. The implementation of Phase II began in January, 2000. This new coverage for children continues the evolution of child health services. SCHIP outreach has resulted in an increase in the number of children enrolled in Medicaid, as well as a cumulative rise in SCHIP enrollment. Over 50,000 children are now enrolled in SCHIP.

B. AGENCY CAPACITY

The MDH is the state agency responsible for administering the Maternal and Child Health (MCH) Block Grant. MCH Block Grant funds are allocated in the central office to the Offices of Women's Health and Child and Adolescent Health. The Children's Medical Program (CMP), the program of services for Children With Special Health Care Needs (CSHCN), is located organizationally in the Office of Child and Adolescent Health. All are located organizationally within Health Services (HS). (see organization chart at www.msdh.state.ms.us). These two HS Offices (Women's Health and Child and Adolescent Health) provide services for the three major populations targeted by the MCH Block Grant, which are women and infants, children and adolescents, and children with special health care needs.

The MDH operates a statewide network of local health departments and specialty clinics which serve the MCH population. Although the MDH provides services to all 82 counties, only 81 counties have county health departments. Services include prenatal and postnatal care, well child and sick child care, as well as restorative services for CSHCN. This network allows the MDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

County level efforts are coordinated through nine public health districts. The District Chief Nurse

oversees all public health nursing activities in the district and supervises the Maternal-Child Health/Family Planning Coordinator.

Children/Adolescent Health Services

Children's Medical Program

The Children's Medical Program provides medical and/or surgical care to children with chronic or disabling conditions. Program services are available to state residents through 20 years of age. Conditions covered by the Children's Medical Program include major orthopedic, neurological, and cardiac diagnoses, and chronic conditions such as cystic fibrosis, sickle cell anemia, and hemophilia. The program provides community-based specialty care through 19 clinics throughout the State, including a multi-disciplinary clinic centrally located in Jackson at the Blake Clinic for Children in the Jackson Medical Mall.

The CMP has a very strong link with the county health department system. This system is utilized to provide community based CMP application sites, screening and referral services, as well as a base of operations for central office staff when clinics are conducted at the community based level. The CMP has developed very effective lines of communication with the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis and Hemophilia parent and/or support groups, Division of Medicaid, the University of Mississippi Medical Center, and the Choctaw Indian Health Services to ensure that all support services are coordinated for the patients when and where appropriate.

The CMP utilizes the CMP Advisory Council to communicate with and receive feedback from health care providers and consumers. The Advisory Council includes specialty and sub-specialty physicians (pediatricians, pediatric orthopedic surgeons, pediatric cardiologists, etc.), dentists, physical therapists and other health care providers, and parents of CMP patients. Through this effort, providers are advised of program efforts such as the expanded effort to provide services to disabled children under sixteen years of age who receive SSI benefits under Title XVI, and the coordinated efforts to assist CMP patients in finding a medical home. CMP also receives input from the CMP Parent Advisory Committee composed of parents of CSHCN served by the program.

Genetic Services

The Genetics Services Program provides comprehensive services statewide for a broad range of genetic related disorders. Newborn screening is mandated by law and provides testing for PKU, hypothyrodism, galactosemia, and hemoglobinopathies. In March, 2002, congenital adrenal hyperplasia (CAD) was added. In June, 2003, newborn screening was again expanded to include cystic fibrosis, biotinidase deficiency, medium-chain acyl-CoA dehydrogenase deficiency (MCAD) and 32 additional disorders detectable through tandem mass spectrometry. Mississippi now screens for a total of 40 genetic disorders and has one of the most comprehensive newborn screening programs in the nation.

The Mississippi Department of Health added field staff in 1993, which created a Genetics Services team consisting of a nurse, social worker, and clerk in each of the nine public health districts. The genetics team works with county health department staff to assure adequate follow-up, case management, and continuity of care for genetic patients.

Clinical services are provided primarily through referrals to the University of Mississippi Medical Center, Mississippi's only tertiary center. Genetic satellite clinics are also routinely conducted in six public health districts in the state. Sickle cell satellite clinics are conducted in seven strategic locations throughout the state. These satellite clinics make genetic services more accessible for patients and families.

Early Intervention

First Steps Early Intervention Program (FSEIP) is Mississippi's early intervention system for infants and toddlers with special developmental needs and their families. The MDH is the lead agency that ensures an effective and appropriate implemention of IDEA, Part C. Other agencies such as the Mississippi Departments of Mental Health (MDMH), Education, and Human Services collaborate with the MDH and assist with the direct provision of early intervention services, referrals of potentially eligible infants and toddlers, and funding of the delivery of early intervention services.

First Steps is implemented through an interagency system of comprehensive developmental services for eligible infants and toddlers. The statewide system seeks to minimize the impact of a disabling condition on an infant or toddler and his or her family by identifying and utilizing, to the maximum extent possible, community based resources. The process of identification of an eligible infant to the provision of services and transition of the toddler into an appropriate educational setting is well orchestrated in keeping with the regulations of the Individuals with Disabilities Education Act (IDEA) Part C.

To be eligible for early intervention services through First Steps, a child must have a developmental delay of 25% or 1.5 standard deviations in any one developmental domain. Infants and toddlers with conditions known to cause developmental delays are automatically eligible for services. Additionally, a qualified provider through informed clinical opinion can establish eligibility for a child. Under IDEA's child find component, the identification, location, and evaluation of infants and toddlers birth to age 3 is a shared responsibility of the MDH under Part C and the Mississippi Department of Education (MDE) under Part B of the Act.

The MDH and the MDE have identified barriers to effective local coordination of activities with regard to mandatory activities under the Individuals with Disabilities Education Act (IDEA) Part C regarding child find and transition. A stakeholders group has been conceived to address these issues. It is expected that the work of the stakeholders will result in policy changes at the state level that will allow for exchange of electronic data, modification of existing MDE policies, development of effective performance measures for MDH and MDE activities, and improved identification of children who are potentially eligible for Part C and B services.

In an effort to assess consumer or family satifaction, First Steps conducted a statewide family satisfaction survey to determine the level of satisfaction among people receiving First Steps services. The survey was mailed to more than 3,500 families who experienced First Steps services from 2000 through 2003. By the date selected as the deadline for receiving responses, over 20% of the surveys had been returned. The analysis of these data revealed that 86% of those responding to the survey were satisfied with the services they received.

Early Hearing Detection and Intervention

Early Hearing Detection and Intervention in Mississippi (EHDI-M) functions as part of the First Steps Infant and Toddler Early Intervention Program. EHDI-M is the Mississippi Department of Health's designated program authorized to establish an early identification system. The EHDI-M implements a statewide family-centered comprehensive delivery system of developmentally appropriate services for infants and toddlers with hearing impairments, coordinated within the child's medical home. Universal newborn hearing screening is being implemented in all hospitals delivering greater than 100 infants per year. Aggressive follow-up is provided for infants referred from hospital screens to ensure the completion of diagnostic processes and timely referrals into the early intervention system.

Oral Health

School Mouth Rinse Program

The School Fluoride Mouth Rinse Program is a voluntary program in which elementary school children rinse weekly with 0.2 percent sodium fluoride solution. In 2003, over 20,000 children at 49 schools participated. Fluoride mouth rinse activities are supervised by school staff.

Community Water Fluoridation- Fluoridation of community water systems continues to be the most cost effective public health measure in decay prevention. Mississippi has approximately 40 percent of its total population receiving optimally fluoridated drinking water that serves over one million people. MDH has a public/private partnership to make grants to public water systems to pay for new fluoridation programs.

School-based Dental Sealant Program
In 2000, Public Health District III had ten percent sealant utilization, the lowest in the state. A school-based dental sealant program was initiated to provide preventive dental sealants to second grade children in public schools. From 2001-2003, over 3,700 dental sealants were placed.

Immunization Program

The purpose of the MDH Statewide Immunization Program is to improve the delivery of vaccination and other preventive services to infants, children and/or adolescents in Mississippi. The school-based immunization program makes immunizations available for sixth grade students not previously vaccinated with a booster dose of tetanus and diphtheria vaccine, a second dose of measles, mumps, rubella vaccine, the hepatitis B vaccine series and, if indicated, the varicella vaccine.

Abstinence Education Program

The purpose of the Mississippi Abstinence Education Program (MAEP) is to promote abstinence from sexual activity through education, mentoring, counseling, and adult supervision. Special emphasis is placed on adolescents 10 through 19 years of age who are most likely to experience untimely and unplanned pregnancies. MAEP funding through an Abstinence Education Grant under Section 510 in Title V of the Social Security Act is used to support community, school, and faith-based organizations in teaching social, psychological, and health benefits of abstaining from sexual activity outside of marriage.

State goals of the MAEP are: (1) to increase the number of middle school youth participating in an abstinence education program, and (2) to establish abstinence education programs among diverse racial and ethnic groups.

Organizations can receive financial support annually for a maximum of five years to provide abstinence education. Initial applications are competitive. Continuation of funding is based on the program's performance, reporting, outcome evaluation, and availability of funds. Programs that have reached the five year funding threshold must wait for two years before reapplying for competitive funding through MAEP.

A total of 21 abstinence education programs located in 15 counties throughout the state received financial support through MAEP during FY 2004. These programs enrolled over 21,000 youth and recorded approximately 113,937 encounters with these children.

In Mississippi, abstinence education programs have created a positive environment for youth development within communities by supporting adolescents in making healthy decisions to postpone sexual activity until marriage.

Health Promotion and Education

The Office of Preventive Health provides and supports services aimed at school health, community

health, and worksite programs to improve the health of Mississippians. Health educators work with community groups, schools, and clinics to implement health promotion programs.

School Nurse Program

Since October, 2003, approximately 364 school nurses in Mississippi public schools promoted and protected the health status of adolescents and staff through health services and health education. Of the 364 school nurses in public schools, the MDH only provides oversight for the 51 tobacco nurses. Public school districts provide oversight for the remaining school nurses.

Fifty-one (51) school districts have nurses that are supported by tobacco settlement dollars to reduce and/or prevent the use of tobacco products and other risky behaviors among youth. An additional twenty four (24) nurses are supported through a private foundation to conduct EPSDT in school-based health clinics.

Women's Health Services

The MDH Women's Health programs provide women with and/or assure access to comprehensive health services that affect positive outcomes, including early cancer detection, domestic violence prevention and intervention, family planning, and maternity services.

Breast and Cervical Cancer

The Breast and Cervical Cancer Early Detection Program works to reduce high morbidity and mortality caused by breast and cervical cancer in Mississippi. The target population for the program is uninsured, underinsured, and minority women. Women 50 to 64 years of age are the target group for mammography screening, and women 45 to 64 years are the target for cervical cancer screening.

Domestic Violence/Rape Prevention and Crisis Intervention

The MDH provides funding to 14 domestic violence shelter programs and nine Rape Crisis Center Programs. When requested, the MDH provides brochures, pamphlets and educational materials on a statewide and local level.

Domestic violence shelters strive to meet the individual needs of every victim entering a shelter as a result of domestic violence. Program staff seek to empower and enable through teaching life skills that promote non-violent responses which lead to a more peaceful life. Services include but are not limited to: temporary, safe housing; education regarding domestic violence; child care; transportation; job skills training; assistance in locating permanent housing; medical assistance; financial assistance; group and individual counseling; court advocacy; and transitional or second stage housing.

The rape crisis centers provide preventive services as well as direct crisis intervention services to victims of rape and other forms of sexual assault. Prevention services focus on education to decrease the number of sexual assaults that occur. Although it is the desired outcome, prevention is not always an option. Centers spend a great amount of time providing direct service to victims of sexual assault including: court advocacy; transportation; confidential counseling; family intervention and follow-up services.

During Fiscal Year 2004, a total of 1,055 women and 1,156 children received shelter services in Mississippi as a result of family violence. For Fiscal Year 2004, a total of 1,368 sexual assault cases were reported to rape crisis centers in the State of Mississippi.

Family Planning

The Family Planning Program promotes awareness of and ensures access to reproductive health benefits by encouraging individuals to make informed choices that provide opportunities for healthier lives. More than 77,580 Mississippians received comprehensive family planning services in CY 2004, and approximately 25,000 of those were age 19 years or younger.

The target populations are sexually active teenagers and men and women ages 20-44 at or below 150 percent of poverty level. A fee system with a sliding scale is used. Under this scale, clients with an income at or below 100 percent poverty level are not charged for services. Reimbursement is sought for Medicaid eligible clients.

The family planning program provides:
1. Medical and non-medical counseling about methods of contraception,
2. Medical examination and provision of contraceptive method, and
3. Pregnancy testing and counseling

The family planning program also provides blood pressure screening, clinical breast exams, cervical cancer screening, follow-up of abnormal Pap smears and treatment, treatment for sexually transmitted diseases, preconception care, sterilization, and infertility services. Access to other MDH services such as WIC, immunizations, prenatal care, child health, and children's medical services is provided to family planning clients and their families as needed.

The Family Planning (FP) program requested a Medicaid waiver in 1999 to the state's Medicaid program in an effort to increase the number of women served and the length of time services would be available to them. An evaluation of the program expanded the FP baseline data by examining inter-pregnancy intervals (IP) in the repeat birth population. In order to establish a comparison group for Family Planning, other MDH programs were included in the evaluation. The waiver was submitted to the Centers for Medicare and Medicaid Services (CMMS) in October 2001 and approved in December 2002.

This program represents a collaborative effort between the Division of Medicaid and the Mississippi Department of Health to increase the availability of family planning services to all women of childbearing age (13-44) with incomes at or below 185% of the federal poverty level who would not otherwise qualify for Medicaid. Since the implementation of the FP Waiver Program, approximately 9,000 clients have been enrolled through the MDH's Family Planning Program.

Maternity

MDH Maternity Services Program aims to reduce low-birthweight and infant and maternal mortality and morbidity in Mississippi by providing comprehensive, risk-appropriate prenatal and postpartum care through county health departments.

Approximately 23 percent of the women who gave birth in Mississippi received their prenatal care in county health departments. Public health nurses, nurse practitioners, physicians, nutritionists, and social workers provide this cost-effective, comprehensive primary as well as preventive care. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a critical component of the maternity care effort.

A part-time, board-certified obstetrician/gynecologist will continue to provide consultation statewide for the maternity and family planning programs. The public health team at the district and county level evaluates the maternity patient at each visit, using protocols which reflect national standards of care for maternity patients. Special emphasis is placed on the identification of high-risk factors and ensuring appropriate care to reduce or prevent problems. This includes arranging for delivery by an

obstetrician at hospitals that provide the necessary specialized care for the mother and her baby.

Prenatal Smoking in Mississippi

A study was conducted in 1993 by Drs. Zotti, Replogle and Sappenfield examining trends in prenatal smoking and the effects of such smoking on birthweight, preterm delivery, and infant mortality in Mississippi. The study was a retrospective cohort analysis of 120,429 singleton births in 1995-1997. They found that even though prenatal smoking was decreasing overall, it was increasing among young pregnant women aged 15-19 years. The primary effect of prenatal smoking was lower birthweight; correspondingly, the principal effect of smoking on infant death appeared to be decreased birthweight. In addition, infants of mothers who smoked during pregnancy were two and one-half times as likely to die from SIDS as were infants whose mothers did not smoke. A report from this study was published in the Journal of the Mississippi State Medical Association. The Mississippi Department of Health continues to monitor prenatal smoking among teenage women.

Perinatal High Risk Management/Infant Services System

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) provides a multi-disciplinary team approach to high-risk mothers and infants. Targeted case management, combined with the team approach, establishes better treatment of the whole patient, improves the patient's access to available resources, provides for early detection of risk factors, allows for coordinated care, and decrease the incidence of low birthweight and preterm delivery. These enhanced services include nursing, nutrition, and social work. This team of professionals provides risk screening assessments, counseling, health education, home visiting, and monthly case management.

Medicaid eligible postpartum women who were not eligible for traditional PHRM because they were not high risk, are eligible for postpartum PHRM due to their socio-economic status. In some districts, public health nurses visit postpartum women prior to their discharge from the hospital. In Fiscal Year 2004, the PHRM/ISS program provided services to 26,667 mothers and infants.

Perinatal Regionalization

Regionalization of perinatal services is an effective strategy for decreasing neonatal and infant mortality and morbidity, with pronounced effects on mortality among Very Low Birthweight (VLBW) infants (<1,500 grams). Perinatal regionalization is a system of care that involves obstetric and pediatric providers, hospitals, public health, and includes outreach education, consultation, transport services, and back-transport for graduates from the Neonatal Intensive Care Unit (NICU).

Study of Perinatal Regionalization

A study about perinatal regionalization was conducted among 1,874 very low birthweight infants born in-state and in-hospital to Mississippi residents from 1979 - 1999. The purposes of the study were to (1) determine the proportion of these infants that were born in each level hospital and (2) assess the effects of hospital level on neonatal mortality while controlling for maternal risk factors. Hospitals were categorized as level A to level D, with level A hospitals having the highest level of perinatal services. The findings were:

1. 40% of Very Low Birthweight infants born of Mississippi residents who delivered in-state were born in a level A hospital

2. As hospital levels decreased, mortality significantly increased (when controlling for <1,000 gram infants.) Exception: Large volume level B hospitals

3. Among infants <1,000 grams, mortality incrementally increased as the hospital level decreased

These findings were presented in January 2003 to the original steering committee associated with this study and to the Mississippi Perinatal Association during March 2003. The MDH is in the process of developing a plan to address perinatal regionalization issues.

Closing the Gap on Infant Mortality: African American-Focused Risk Reduction

Closing the Gap is a three-year program funded by the Health Resources and Services Administration (HRSA) through the Bureau of Maternal and Child Health to accelerate the rate of change among African American populations to reduce significant disparity in infant mortality related to low birthweight, preterm and sudden infant death syndrome (SIDS). A combination of medicinal, behavioral, educational, and service enhancement risk reduction interventions are being implemented in two target areas in Mississippi. These target areas include five counties in the Delta area (Bolivar, Coahoma, Leflore, Sunflower, and Washington); and three counties within the Jackson Metropolitan area (Hinds, Madison, and Rankin).

Considerable disparity exists between white and African-American infant mortality in Mississippi, which greatly affects the health of the state. Closing the Gap will address this problem by implementing three primary goals; (1) Decrease infant mortality related to low birthweight and preterm birth by implementing appropriate interventions in targeted regions; (2) Decrease infant mortality related to low birthweight and preterm birth by working to enhance the perinatal regionalization system, especially in targeted areas; and (3) Decrease infant mortality related to SIDS through enhanced African-Americans risk reduction education at both the community and professional levels in targeted communities.

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is part of the Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birthweight. It is an ongoing, population-based, state-specific source of information on selected maternal behaviors and experiences that occur before and during pregnancy and during a child's early infancy.

Since the start of data collection, PRAMS continues to successfully survey mothers throughout the state of Mississippi. PRAMS surveys approximately 176 mothers a month. Currently, PRAMS has expired thirty-three (33) batches with five remaining active. PRAMS received its first data set for 2002 in August, 2004 with a response rate of 61%. The overall state response rate fell short of the 70% rate regarded by PRAMS as the epidemiologically valid threshold. Thus, PRAMS will not include the 2002 data in CDC publications or analyses.

All PRAMS reports and raw data for 2003 births has been submitted to CDC. Tabulation shows an overall response rate of 73%. MDH's Vital Records Department will submit Mississippi birth files for 2003 to CDC to obtain weighted data in order to utilize PRAMS data.

Phase five (5) of the PRAMS survey began January 14, 2004. The mail and phone survey was revised and approved by CDC. PRAMS staff collaborated with the Dental and STD/HIV programs to ask state specific questions of concern to the survey. Also, the MDH's PRAMS staff submitted a poster presention entitled "A Year in Review: Making the Program Work" at the Tenth Annual Maternal and Child Health Epidemiology Conference in Atlanta, Georgia.

Sudden Infant Death Syndrome (SIDS)

The purpose of the Mississippi Department of Health's Sudden Infant Death Syndrome (SIDS) program is to provide a statewide system for the identification of SIDS deaths, and to offer counseling and referral services as indicated for families with sudden unexplained infant deaths. The program also provides assistance in the campaign to educate the general public on SIDS risk reduction.

SIDS is defined as the sudden death of an infant under one year of age which remains unexplained after a thorough investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical records (Willinger, et al., 1991). Each county health department is encouraged to identify a SIDS contact person whom the coroner can notify of an infant death caused by SIDS. County health department staff initiate contact with the family (phone, mail, home visit) to offer support, counseling, and referral to indicated services.

The Mississippi Department of Health partnered with different organizations, including the Mississippi SIDS Alliance and the Mississippi SIDS Coalition, to conduct outreach activities in 2004. During CY 2001 and 2002, SIDS remained the third leading cause of infant deaths in the state. Fifty-four infants died from SIDS in 2001, and 55 infants died in 2002.

A SIDS database was develop in 2003 to effectively compile data on SIDS in Mississippi and to allow analysis of SIDS reports in an effort to identify trends and implement intervention strategies.

C. ORGANIZATIONAL STRUCTURE

Brian W. Amy, MD, MHA, MPH, assumed the leadership role in October, 2002, as the MDH's new State Health Officer. Dr. Amy has created structural changes that should enhance MCH programs and policies. MDH has also experienced many personnel changes in office and bureau directors.

Health Services (HS) is responsible for all Maternal and Child Health (MCH) functions. HS administers programs that provide services to the Maternal and Child Health/CSHCN population. Each Office within HS, through the MCH Block Grant, supports services to women and infants, children and adolescents and CSHCN through local county health departments and specialty clinics (see organization chart on agency website www.msdh.state.ms.us).

In July 2004, HS added the Office of Health Promotion and selected epidemiologic surveillance systems related to chronic disease and asthma. In anticipation of the expansion, HS leadership conducted two meetings. During the first meeting, programmatic activities were discussed with HS staff leaders. At the second meeting, Dr. Donna Peterson from the University of Alabama at Birmingham facilitated strategic planning. HS created its vision "Leading and Empowering People for Healthier Lives" and identified strategic goals. Future strategic planning activities are slated to occur.

BIOGRAPHICAL SKETCHES

Daniel R. Bender, MHS, formerly the Director of the Office of Child Health, currently serves as the Director of Health Services. Mr. Bender was the Director of the Genetics Program from 1983 to 2000, where he worked toward the passage of laws mandating newborn screening for PKU, T4 (TSH), Hgb and Galactosemia. Mr. Bender started nine satellite genetic clinics in the state and started the first genetics database in Mississippi. He also developed the Mississippi Birth Defects registry. Mr. Bender's medical experiences include registered Emergency Medical Technician for Baldwin Ambulance and Director of Rankin County Emergency Medical Services. His education includes a Bachelor of Science Degree in Special Education and Master's Degree in Health Science. Mr. Bender has made many presentations which include Health Care for the Poor, the National Neonatal Screening Symposium, and the American Public Health Association.

LeDon Langston, MD, is a Board Certified OB/GYN physician currently serving as medical consultant to the Office of Women's Health in Health Services of the MDH. Recently retired from 25 years of

private practice at Southwest Mississippi Regional Medical Center in McComb, Mississippi, he joined the MDH in February, 2001. He brings with him experience of 6000 deliveries and 3000 gynecological surgeries and hopes to serve as a bridge between private and public health practices. Dr. Langston is a former flight surgeon in the United States Air Force. He is a former member of the Mississippi Medicaid Medical Advisory Committee; President of the Mississippi OB/GYN UMMC Society; and the Medical Policy Advisory Committee for Blue Cross/Blue Shield of Mississippi. His present interests include the Teen Pregnancy Prevention and Breast and Cervical Cancer Programs.

Floyd Carey, MD, is a Board Certified Pediatrician currently serving as the medical consultant for the Office of Child Health within Health Services of the Mississippi Department of Health. Dr. Carey recently retired from private practice at Southwest Mississippi Regional Medical Center in McComb, Mississippi. He joined the Mississippi Department of Health in February, 2002. Among his varied projects, he has been actively involved in changes in genetic screening.

Louisa Young Denson MS, MPPA, is currently the Director of the Office of Women's Health for the Title V program within the Mississippi Department of Health. Ms. Denson has served in various capacities of public health. Previously, she served as the Director of Disparity Elimination, Director of Minority Affairs, Office Systems Advisor for all clerical staff with the agency, Immunization Representative for 11 counties in District V, Hinds County Office Manager (which consisted of 11 clinics), Director of the Mary C. Jones Clinic, Public Health Advisor for the Sexually Transmitted Disease Program and a clerk in Vital Records and Statistics. Ms. Denson has a Master's in Public Policy and Administration, Bachelor's degree in Social Work, and is a licensed social worker. She has also completed the Certified Public Managers Program with the State Personnel Board.

Geneva Cannon RN-C, MHS, is Director of the Office of Child and Adolescent Health. Ms. Cannon has over twenty years of experience as a pediatric nurse in critical care, public health, and administration. She was employed with the MDH in the late 1980's and early 1990's as a nurse with the Genetics Program and later as a nurse consultant with the Office of Child and Adolescent Health. Her career also includes working as Director of Licensure and Practice with the Mississippi Board of Nursing. Prior to her current position, she worked as the Program Coordinator in the planning and implementation of the separate insurance plan for the state's Children's Health Insurance Program.

Lawrence H. Clark is the new Director of the Children's Medical Program (CMP), Mississippi's Title V Children with Special Health Care Needs (CSHCN) program. He replaces the previous director, (Mike Gallarno) and has over 25 years of supervisory and management experience. He has worked with the Allstate Insurance Company's Regional Office in Jackson, Mississippi, and their corporate headquarters in Chicago, Illinois. He has 13 years of managerial experience with the Mississippi Development Authority, formerly known as the Mississippi Department of Economic and Community Development. Before joining the MDH staff, he was employed with the Mississippi Department of Education, Office of Special Education where he managed several statewide initiatives.

Kathy Gibson-Burk is the Director of the Office of WIC with the MDH. She came to the Department of Health in 1994 as the District Social Work Supervisor for the West Central Public Health District V. In 1997 she was promoted to the State Social Services Director; and in 1999 she received another promotion as the Deputy Field Services Director. She has over 22 years of service and management experience in state government, having worked 13 years with the Mississippi Department of Human Services. She earned a Bachelor's of Social Work degree from Mississippi University for Women, and a Master's of Social Work degree from the University of Southern Mississippi. She also received the Certificate of Achievement from the Tulane School of Public Health and Tropical Medicine for completion of the South Central Public Health Leadership Institute and is a graduate of the Certified Public Manager's Program through the Mississippi State Personnel Board.

Benny Farmer became the financial director of Health Services on May 1, 2003. He has considerable experience with grants and budgeting due to working in the MDH Bureau of Finance and Accounts for sixteen years, first as an accountant in various areas, and then as director of the Division of Budgeting/Purchasing/Grants. He holds a Bachelor's degree in accounting from the University of

Southern Mississippi.

Virginia L. Green, MD, began working with Children's Medical Program (CMP), Mississippi's Title V CSHCN program, in 1986, as Pediatric Consultant. Other pediatric experience includes: private practice in Montgomery, AL, 1980- 1983; pediatrician for District V, Mississippi State Department of Health, 1983-1986; pediatrician and Assistant Professor of Pediatrics, Department of Pediatric Gastroenterology, University of MS Medical Center (UMC), 1991 - 1993. She also served as a review pediatrician for Mississippi Disability Determination Services (DDS), reviewing childhood cases for eligibility for Supplemental Security Income (SSI) and Medicaid, 1991 - 1993. In 1994, she returned to CMP and recently replaced Dr. Marilyn D. Graves as the Program's Medical Director. She has served on several committees relating to children with special health care needs and continues to serve on the UMC Visiting Teaching Faculty and on the Board of Directors for the Spina Bifida Association of MS.

Ulysses Conley, B.S., MPPA, CPM, currently serves as the principal grantwriter for Mississippi's Maternal and Child Health Block Grant. He was employed by the Mississippi Department Health (MDH) in October, 1991, as a Senior Analyst with the Office of Policy and Planning. In February, 1996, he joined Health Services as a Principal Analyst/Grantwriter for the state's Title V program.

Anna Lyn N. Whitt, MPH, MSW is a licensed social worker currently serving as the assistant director of the Health Services Data Unit. Mrs. Whitt, formerly an Operations Management Analyst, Principal, coordinated the Title V MCH Block Grant Five Year Needs Assessment and manages the State Systems Development Initiative. She joined MDH in August 2003 after completing a dual degree program at the University of Alabama and University of Alabama at Birmingham. Before coming to Mississippi, she worked for the Alabama Department of Health as a Public Health Social Worker. Mrs. Whitt has presented several abstracts at state and national conferences regarding needs assessment and community work. Her current role includes managing activities in the data unit and developing data infrastructure and capacity.

Lei Zhang, MS, MBA, also a PhD candidate in Preventive Medicine at the University of Mississippi Medical Center, is a Lead Analyst and new director of the Health Services Data Unit. He is the primary investigator of the Mississippi Asthma Program. In addition, he oversees all aspects of data collection and data analysis within Health Services. Mr. Zhang's research interests include health survey data analysis and spatial investigation using GIS. He has published several articles in peer-reviewed journals. In addition, he has given numerous presentations in national and local conferences. Currently he is a member of both the American Statistical Association and the American Public Health Association.

Laws and Authorizations:

A number of state laws guides Mississippi's public health system and provides authorization for certain programs and policies. These laws are added as an attachment to this file for review.

D. OTHER MCH CAPACITY

D. Other MCH Capacity

At the state level, HS administers programs that provide services to the MCH/CSHCN population. Within HS there are three Offices that serve this population. They are listed below with the Central Office FTE of each:

Office of WIC 43
Office of Women's Health 22

Each office, through the MCH Block Grant, supports services to women and infants, children and adolescents and CSHCN through local county health departments and speciality clinics. The MDH provides case management, childhood immunizations, well-child assessments, limited sick-child care, and tracking of infants and other high-risk children. Services are targeted towards women and children whose family incomes are at or below 185 percent of the federal poverty level. The MDH provides services to more than 120,000 children annually. Adjunct services such as the First Steps Early Intervention System (FSEIS), Genetic Screening, WIC, and the Children's Medical Program are important components of the comprehensive Child/Adolescent Health Program. Services are provided through a multi-disciplinary team approach including physicians, nurses, nutritionists, and social workers, and provides early identification of potentially disabling conditions and linkages with providers necessary for effective treatment and management. The MDH provides services to women and infants through its family planning, maternity, and Perinatal High Risk Management/Infant Services System (PHRM/ISS) programs.

Children and adolescents are targeted for periodic health assessments and other services appropriate for their age and health status. Those services may include, but are not limited to:

(a) immunizations;
(b) genetic screening and counseling;
(c) routine and periodic screening, diagnosis and treatment for EPSDT eligible infants and children;
(d) well-child and sick-child care;
(e) vision and hearing screening;
(f) WIC services;
(g) counseling regarding: reproductive health issues, alcohol,tobacco, and substance abuse, and sexually transmitted diseases;
(h) comprehensive developmental services from child birth to age 3;
(i) dissemination of information on the benefits of protective dental sealants to families of children receiving health department services; and,
(j) referral and case management for treatment of conditions where services are not readily available; and,
(k) PHRM/ISS

Children with Special Health Care Needs, children, and adolescents receive direct personal health care services defined as interventions for high risk individuals, case management, care coordination, primary and preventive care, health education and counseling.

The CMP has developed very effective lines of communication with the UMMC, the March of Dimes, Cerebral Palsy Foundation, Cystic Fibrosis Foundation, and the local chapter of the Hemophilia Foundation to make sure that all support services are coordinated for the patients where and when appropriate.

The CMP also maintains a major link with health care providers through the CMP Advisory Council, which includes physicians, parents, hospital representatives, anesthesiologists, physical therapists, social workers and other health care providers. Through these resources, providers are advised of the expanded effort to provide services to disabled children under sixteen (16) who receive SSI benefits under Title XVI. The Children's Medical Program has led the way to coordinate communication between CMP, Social Security, and the State Disability Determination Office.

The CMP works to develop and strengthen lines of communication between all state agencies who provide assistance to CSHCN and to the blind and disabled population under sixteen (16) years of age. This includes invitations to CMP Advisory Council meetings, both parent and professional.

The Title V agency installed a toll-free telephone line in cooperation with the bureaus of WIC and Women's Health. The line provides assistance to clients seeking information about MCH services, family planning, Medicaid, WIC, and other services. This valuable tool encourages early entry into prenatal care and further links the private and public sectors. Information about the line is publicized through a newsletter of the Mississippi Chapter of the American Academy of Pediatrics, brochures, posters, and a Teen Help Card.

Toll-free numbers in the agency which are directly related to services for the MCH/CSHCN population include a Genetics/Early Intervention line, an HIV/AIDS line, and a CMP line.

Strategic Planning
In 2004, the MDH contracted with Dr. Donna Petersen, a well-known MCH professional, in order to provide strategic planning for Health Services. Office directors attended the two day training so that a clear and concise plan of action for Health Services could be determined.

E. STATE AGENCY COORDINATION

E. State Agency Coordination

There are various organizational relationships that exist between the MDH and other human service agencies which work to enhance the capacity of the Title V program. Examples of MDH's coordination efforts with other human service agencies are as follows:

Substance abuse programs.
The Born Free project, which originated with the MDH, networks available community resources for the provision of services to substance-involved pregnant women and their infants. Other agencies involved in the Born Free network include: (a) the University of Mississippi Medical Center; (b) Marian Hill Chemical Dependency Treatment Center; (c) New Life for Women (housing); (d) Catholic Charities (provides direct primary treatment services and transitional program services); (e) community health centers; (f) Jackson Recovery Center; (g) state mental health centers and state hospital; (h) parole officers and the court system; and, (i) sexual assault and domestic violence shelters and other treatment centers. Born Free is now administered by Catholic Charities.

March of Dimes.
The MDH partners with the March of Dimes to increase the awareness of folic acid as it relates to birth defects. The March of Dimes launched a campaign to raise awareness of the growing problem of prematurity and to decrease the rate of preterm births. Premature infants are more likely to be born with low birthweight and suffer mild to severe disabilities and/or death. Prematurity is the leading cause of infant death before the first month of life.

Mental Health.
The MDH county health departments make referrals to community mental health centers for families who have experienced Sudden Infant Death Syndrome (SIDS) and other infant deaths if requested by the family. Also, the MDH has a representative who participates on the State Developmental Disabilities Council. The First Steps Early Intervention System (FSEIS) has recently contracted with the Bureau of Mental Retardation in the Department of Mental Health (DMH). Each of the five regional retardation centers submitted a proposal to expand their capacity to serve infants and toddlers and their families in natural environments, thus moving away from the traditional facility-based service delivery model to a family-centered natural environment. These contracts expand the MDH's capacity to deliver services in some extremely rural and impoverished areas of the state. A representative from the Department of Mental Health serves as an ex-officio member of the Infant Mortality Task Force.

First Steps Early Intervention System (FSEIS).
The FSEIS is structurally located within the Office of Child and Adolescent Health, and has established an Interagency Coordinating Council bringing together the State Departments of Mental

Health, Education and Human Services, universities, parents of children with special needs, providers of services, and others, to develop a comprehensive system of family-centered, community-based, culturally-competent services. Local interagency councils support the planning, development, and implementation of the system at the community level.

Mississippi Statewide Immunization Program.
The MDH's Statewide Immunization Program is primarily funded by the Centers for Disease Control and Prevention, but MCH funds are used to support some staff in local health department clinics. A statewide coalition has been established, which is composed of health care professionals (organizations and individuals), immunization providers, community-based organizations, social/civic groups, lay people, and others with an interest in improving the immunization status of Mississippi's children. This broad-based group provides the framework for promoting the implementation of the immunization monitoring and tracking system in non-health department clinics.

Department of Human Services (DHS).
DHS provides services that include case management, child care for the developmentally disabled, services for the chronic mentally ill, abstinence education, and treatment for alcohol and chemically dependent adolescents.

DHS Office of Children and Youth uses funds for day care, while the Division of Aging and Adult Services uses Social Services Block Grant (SSBG) funds for home health aides, ombudsmen services, transportation for elderly, case management for adults, adult day care, home delivered meals for adults, and respite care. The MDH no longer receives SSBG funds from the DHS to assist in its efforts to provide needed contraceptive services to teens, however, a representative of the MDH is a member of the DHS Out-of-Wedlock Task Force. A representative from DHS is an ex-officio member of the Infant Mortality Task Force and the Pregnancy Risk Assessment and Monitoring System (PRAMS) Advisory Committee.

DHS administers the federal Child Care Development Block Grant (CCDBG) which has two basic component areas. The provision of actual child care services comprises 75 percent of the budget. The Quality Child Care Development portion of the budget provides funds for training of child care providers, improvements to day care centers, and media centers. Some CCDBG funds are provided to the MDH for child care facilities licensure.

Division of Medicaid.
The Division of Medicaid is a key player in the reimbursement for services to patients seen in MDH clinics. In addition to a cooperative agreement, which allows billing for specific services provided to PHRM/ISS and other non-high risk patients, the MDH assists Medicaid in assessing pregnant women and children for Medicaid and CHIP eligibility using MDH staff and outstationed eligibility workers and a two-part eligibility form with 185 percent of poverty as a threshold, thereby preventing untimely delay for clients who need Medicaid coverage. Medicaid staff and MDH staff meet quarterly to discuss PHRM/ISS progress and concerns.

Presumptive Eligibility
Unfortunately, during 2002 the Mississippi Legislature rescinded the funding and presumptive eligibility was never implemented.

Community Health Centers/Primary Health Care Association.
A primary care cooperative agreement with the Bureau of Primary Health Care has been administered by the MDH since 1985. The cooperative agreement provides a mechanism for joint perinatal planning and provider education between the state MCH program and the 21 community health centers (CHCs). Perinatal providers are placed in communities of greatest need through a joint decision-making process of the Mississippi Primary Health Care Association (MPHCA) and the MDH Primary Care Development Program, making access to care available to many pregnant women and their infants. The Office of Rural Health (ORH) works closely with Primary Care Development to promote the recruitment and placement of providers in rural areas.

The MDH, through its Office of Rural Health, administers the Medicare Rural Hospital Flexibility (FLEX) Grant, which funds the Critical Access Hospital program. This program is designed to foster the growth of collaborative rural health delivery systems across the continuum of care at the community level with appropriate external relationships for referral and support. This should result in improved access to care, economic performance and viability of rural hospitals, and ultimately, health status of the community. The Office of Rural Health contracts with the Mississippi Hospital Association to provide staff support and programmatic assistance for the FLEX program.

The Mississippi Primary Health Care Association is the lead agency for the Mississippi Access to Rural Care (MARC) program, funded by the Robert Wood Johnson's Southern Rural Access Program. The program supports work to increase the supply of primary care providers in underserved areas, strengthen the health care infrastructure and build capacity at the state and community level to address healthcare problems. To achieve these goals, MARC is focusing on rural health leadership development, recruitment and retention of primary healthcare providers, rural health network development, and revolving loan fund development. The MDH has a contractual arrangement with the Primary Health Care Association to provide staff support for recruitment and retention efforts. In addition, the MDH holds a seat on the MARC Board of Directors.

During the 1999 Legislative Session, House Bill 403 was passed that provided funding to the MDH for the purpose of contracting with Mississippi Qualified Health Centers (MQHC). These funds are used to increase access to preventive and primary care services for uninsured or medically indigent patients, and to create new services or augment existing services provided to uninsured or medically indigent patients. Services include, but are not limited to, primary care medical and preventive services, dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services.

The Mississippi Primary Health Care Association (MPHCA) is one of the 24 primary care associations funded by the Health Resources and Services Administration (HRSA) to implement a Medicaid/CHIP Outstation Demonstration Pilot. This Medicaid Demonstration Pilot has expanded on the foundation laid by the regional and national project TEAM (The Early Access Model for Integrated Health Care). The Medicaid/CHIP Demonstration has built these existing partnerships by including partners in "Train the Trainer" sessions on the Medicaid/CHIP application process and how to complete the one-page Medicaid/CHIP application.

The MDH HIV/AIDS Program maintains contractual agreements with a number of community agencies. The Jackson/Hinds Community Health Center provides AIDS education and information services to their clients in Hinds County and the Jackson public school system. Another agreement with the Aaron Henry Health Center in Clarksdale provides AIDS education and information to residents of Quitman, Tallahatchie, Tunica and Coahoma counties.

The Family Planning Program maintains six contracts with community health centers and four contracts with universities and/or colleges for the provision of contraceptive supplies and educational materials. These contracts have been formulated with the Aaron Henry Health Center, Arenia Mallory Health Center, G.A. Carmichael Health Center, Northeast Mississippi Health Care, Inc., Southwest Health Agency for Rural People, Access Family Health Services, Jackson State University, Alcorn State University, Tougaloo College, and Coahoma Community College.

The Breast and Cervical Cancer Screening and Early Detection program contracts with community health centers, health departments, private providers, and hospitals to provide screening services, diagnostic services, referrals and case management. The target populations for the program are uninsured, underinsured, and minority women. Women 50 years of age and older are the target group for mammography screening, and women 45 years and older are the target group for cervical cancer screening.

The Bureau of Immunization located in the Office of Communicable Disease, provides vaccine to

private physicians and community health centers that are enrolled as Vaccine for Children providers.

The Bureau of WIC has a contractual relationship with 19 community health centers for the purpose of certification of women, infants, and children for provision of WIC food and/or formula through distribution centers located throughout the state.

Marion County Health Department in Public Health District VIII and the Lawrence County Health Department in Public Health District VII work cooperatively with local community health center staff, whereby community health center staff provide PHRM/ISS services to maternity patients receiving prenatal care at the county health departments.

Those community health centers that provide EPSDT services are also subject to the Division of Medicaid requirement for periodic lead screening. As the MDH expands its statewide program of lead screening and follow-up to improve access to this service for potentially vulnerable populations, the cooperation of community health centers continues to be critical to its success in implementing community based interventions.

A representative from the MPHCA serves as an ex-officio member of the Infant Mortality Task Force.

Children's Medical Program (CMP).
CMP, the state CSHCN program, maintains an Advisory Council whose members include medical and other service providers and parents of CSHCN. Medical service providers of the Advisory Council include private physicians, a dentist, orthotics/prosthetics provider, and staff physicians of the University of Mississippi Medical Center, the only state funded medical teaching and tertiary care facility. A representative from the MDH also serves on the State Developmental Disabilities Council. CMP maintains a Memorandum of Understanding with the Mississippi Disability Determination Service providing for the exchange of respective program eligibility criteria in cross referral of CSHCN for services.

The Children's Medical Program now maintains a Parent Advisory Committee composed of parents of CSHCN who are covered by the program. Parents provide input regarding the services that their children received from the CSHCN program.

Maternal Death Review.
In the past, the Mississippi State Medical Association's Committee on Maternal and Child Care reviewed all cases involving maternal deaths in the state. All maternal death certificates and matching birth certificates (if there was a live birth) or fetal death certificates were sent to the director of the Office of Women's Health. District and county health department staff were requested to gather information regarding prenatal care, labor and delivery, postpartum care and any other information surrounding the death. This information was used for both the in-house review and for the review by the Mississippi State Medical Association's Committee on Maternal and Child Care. The death certificates were revised in 1998 and a block added to check if the decedent had been pregnant within the last 90 days.

The MDH is currently in the process of developing the Statewide Maternal and Infant Mortality Surveillance System. Reviews of maternal deaths will be conducted under the auspices of the MDH, but with the collaboration of the University of Mississippi Medical Center (CMMC) and the Mississippi State Medical Association. A pilot program is currently being conducted in eight target communities including Bolivar, Coahoma, Leflore, Hinds, Madison, Rankin, Sunflower, and Washington counties.

Infant Mortality Task Force.
The Infant Mortality Task Force (IMTF), was created by the Mississippi Legislature. The Legislature directed the IMTF to work with the administrative heads of the Department of Health, Department of Education, Department of Mental Health, Department of Human Services, and the Division of Medicaid, to develop recommendations aimed at reducing infant mortality and morbidity in Mississippi. Members are appointed to the IMTF by the Governor, Lieutenant Governor, and Speaker

of the House.

According to its statutory authority, the Task Force shall:
1.Serve an advocacy and public awareness role with the general public regarding maternal and infant health issues;
2.Conduct studies on maternal and infant health and related issues;
3.Recommend to the Governor and the Legislature appropriate policies to reduce Mississippi's infant mortality and morbidity rates and to improve the status of maternal and infant health; and
4.Report annually to the Governor and the Legislature regarding the progress
made toward the goals and the actions taken with regard to recommendations previously made.

In 2003 and 2004 the IMTF went through a period of transition. Appointments are now based on the Mississippi Supreme Court Districts rather than Congressional Districts. The Mississippi Department of Heath staff continue to communicate with members of the IMTF and work to promote its recommendations.

Dietetic Education.
The CSHCN program nutrition staff are working with university affiliated nutrition education programs in the state to develop and implement community-based experiences for senior or graduate nutrition/dietetic students. These experiences are designed to prepare the students to work with special needs populations and to be significant contributors to the interdisciplinary teams that assist families with their child's care.

Oral Health Policy Task Force
In October 2001, Mississippi's Governor Musgrove hosted six states in Jackson for a third National Governors Association (NGA) Policy Academy on "Improving Oral Health Care for Children." The meeting focused on developing an action plan to address oral health care needs in children and building alliances between the public and private sectors to implement the plan. The work done over the course of the Policy Academy meeting provided some vision for how policymakers should address poor oral health. For example, dental sealants were identified as a need during the Policy Academy, and as a result, the MDH developed a collaborative pilot project between the School of Dentistry at the University Medical Center and the Delta Hills Public Health District. The policy team also identified the need for a full-time Public Health Dentist in the state, and this position was created and filled in 2002.

The Oral Health Task Force has developed strategies to improve oral health care, and they are as follows:

1. Establish effective oral health infrastructure to assure that every child enjoys optimal oral health.
2. Ensure available, accessible, affordable and timely access to dental care.
3. Implement and assure effective oral health programs that prevent disease and improve oral health.
4. Ensure adequate funding for programs that assure good oral health for children. //2004//

The Oral Health Task Force has met approximately six times since established. The goal of this task force is to develop a Statewide Oral Health Plan, and to conduct regional public health meetings to present and/or share data with health care providers.

Rural Health Program.
The MCH program works collaboratively with the Office of Rural Health (ORH) in resolving access to care issues. This program is administered by the MDH Office of Health Protection. This program has been funded through a Federal Office of Rural Health Policy grant since August, 1991. There are four mandated functions under the grant: (1) to establish and maintain a clearinghouse of rural health issues, trends, and innovative approaches to health care delivery in rural areas; (2) to coordinate activities carried out in the state that relate to rural health care in order to avoid redundancy; (3) to identify federal and state programs for rural health and provide technical assistance to public or nonprofit entities regarding participation in the programs and; (4) an option to provide technical

assistance to rural hospitals and communities on recruitment and retention of health care professionals.

Centers for Disease Control and Prevention and Health Resources and Services Administration
Most of Health Services' funding, the office that houses the MCH and CSHCN programs, is reliant on federal funds. Less than 2% of total funding to Health Services is provided by the State of Mississippi. Therefore, many MCH programs not funded through Title V but working in cooperation with Title V coordinate with national resources such as CDC and HRSA/MCHB. Program staff are constantly in touch with project directors at the national level to ensure holistic services provided to the MCH population.

Other MCH Programs
Program directors and workers consistently seek the support and knowledge of other states' MCH programs. For example, the SSDI coordinator seeks the technical assistance and advice of other state SSDI programs, such as Iowa's SSDI program and Alabama's SSDI program. Also, the Family Planning Director and Director of the Office of Women's Health sought the assistance of Alabama's Family Planning professionals when developing a Family Planning Waiver Program for women in Mississippi. The coordination between Mississippi and other states is consistent and ongoing.

F. HEALTH SYSTEMS CAPACITY INDICATORS

F. Health Systems Capacity Indicators

#01- The rate of children hospitalized for asthma (10,000 children less than five years of age)

Status:

The MDH completed a four-year (1999-2002) pilot surveillance study of asthma hospital visits in the central tri-county area (Hinds, Rankin, and Madison counties). This area is the state's largest metropolitan center, and is representative of other areas within the state. Data were provided to MDH by the seven acute care hospitals in the area on all hospital visits, regardless of type. Data elements captured included medical record numbers, all primary 493 ICD-9-CM codes, patient names, social security numbers, age, sex, race, type of admission, and dates of admission and discharge. These data were analyzed for prevalence, age-adjusted, and morbidity rates.

Trends shown during the four-year period were alarming, especially when looking at racial disparities in both the number of hospital visits by African Americans (72% of all visits), and in the number of hospital visits made by African American females (40%). There are also obvious disparities between age groups, with 41% of the total visits being made by those under the age of 15. Of these, 2,650 were emergency room visits, 696 were inpatient visits, and 3,375 were outpatient visits. White males accounted for 1,421 (10%) visits compared to 5,428 (32%) by African American males. White females accounted for 2,452 (18%) visits compared to 5,983 (40%) by African American females. In variation to the previous study, the percentages show a far greater rate of morbidity and disparity.

According to data collected by the MDH's Asthma Surveillance Project within the Jackson Metropolitan Area, children between the ages of 0-4 (< 5) accounted for 3,129 of the 14,629 visits. Of these, 1,160 were Emergency Room visits, 388 were Inpatient visits, and 1581 were outpatient visits.

During the most recent data collection, the MDH's Asthma Program collected hospitalization data for 2002 -- 2003 for the tri-county Jackson Metropolitan area (Hinds, Madison, and Rankin counties). The hospitals provided data for all inpatient, outpatient, and emergency department visits with a primary ICD-9 Code of 493.00 - 493.99. Although these data were collected in a limited geographic area, the population groups in this area are representative of the statewide population.

Children between the ages of 0-4 (<5 yrs.) accounted for 1,602 (25.4%) of the total 6,309 visits; children between the ages of 5-14 accounted for 1,477 (23.4%). So, nearly half of all hospital visits

were made by children under 15 years of age.

Of the hospital visits made by children in the 0-4 age group, 1436 (89.6%) were made by African American children. In the 5-14 year age group, 1368 (92.6%) hospital visits were made by African American children. The overall hospital visit rate for children under age five was 5.6 per 10,000.

#02- The percent of Medicaid enrollees whose age is less than one year who receive at least one initial periodic screen.

Status:
According to the latest data available (CY 2003) from the Mississippi Division of Medicaid, of the 80,456 Medicaid enrollees whose age is less than one, 61% (48,990) received a screening service.

#03- The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

Status:

According to CY 2003 data from the Mississippi Division of Medicaid, there were 718 children enrolled in SCHIP who were less than one year of age at some point during the year, and of these children, 542 (75.5%) had a visit to a health care professional (physician, nurse practitioner, etc.) before one year of age.

#04- The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Status: According to 2004 data from the Office of Health Informatics, 84.1 percent of women (15 through 44) with a live birth during the reporting year had observed expected prenatal visits greater than or equal to 80 percent of the Kotelchuck Index. This represents slightly more than a 2% decrease from the percentage reported during CY 2003.

#05- Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Status:
Only 28% of Medicaid women entered prenatal care during the 1st trimester (Form C2). Currently, neither payment source on the birth certificate nor matching birth and Medicaid files are available in Mississippi due to the installation of a new operating system for birth and death registration. After the new system has been installed, Mississippi will move to the new birth certificate which will include payment source at birth.

#06- The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

Status:
The percent of poverty level of infants 0 to 1 for eligibility in Medicaid is 185% for the Medicaid program and 200% for the SCHIP program. For pregnant women it is 185% of the poverty level for Medicaid. For pregnant women under 19, it is 200% of the poverty level for the SCHIP program.

#07- The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Status:
During Calendar Year 2004, there were 83,629 EPSDT eligible children ages 6-9. Of these, 43.6% (36,421) received dental services.

#08- The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

Status:
One hundred percent of Mississippi's SSI beneficiaries less than 16 years old received rehabilitative services from the state's CSHCN program, either directly or indirectly. Through a series of meetings with the Division of Disability Determination Services (DDS) representative, it was determined that all SSI beneficiaries less than 16 receive Medicaid. Due to Medicaid regulations, all children on Medicaid are eligible for rehabilitative services. If a child on Medicaid needs a particular service not covered under Medicaid, the CMP will either cover the service if the child is eligible for CMP or assist with the development of a plan of care for the child's physician to submit to Medicaid to achieve coverage. Therefore, all children under the age of 16 who are on SSI are provided rehabilitative services through a collaborative effort of CMP, DDS, and Medicaid. A copy of this agreement is available from the CMP upon request.

#09(A)- The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

Status:
Scores pertaining to this indicator are on Form 19. The MDH is continuing to grow in its data capacity. The major change from 2003 is the first year of data collection for PRAMS. Mississippi will be publishing localized results during 2003 and 2004. Another change is that the Mississippi Legislature charged the Mississippi Hospital Association to create a hospital discharge data system. The MDH will work with them as this system is developed and pursue agreements for data sharing. Lastly, the MDH is changing the birth and death registration operating system. Once the change has occurred and the new birth certificate system is implemented, the state's Title V (MCH) office will work with the MDH Office of Health Informatics to conduct regular data linkages.

#09(B)- The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

According to the latest data (2003) from the Mississippi Youth Risk Behavior Survey (YRBS) conducted biannually, 25 percent of adolescents in grades 9 through 12 reported using tobacco products in the past month.

#09(C)- The ability of States to determine the percent of children who are obese or overweight.

Status:
Efforts are being made to capture these data through a number of initiatives. The Mississippi Council on Obesity Prevention and Management has made a number of recommendations which may impact child health activities. MCH staff are actively involved in ongoing projects and grant initiatives. According to the 2003 Mississippi YRBS, 16 percent of high school students and 19 percent of middle school students were overweight (95 percentile or greater for height and weight). In addition, 16 percent of high school students and 21 percent of middle school students were at risk of becoming overweight (85th through 94th percentile for height and weight).

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

In an effort to carry out the core functions of public health, the MDH relies on the work of public health team members across the state to assist every community in the state to achieve the best possible health status for its citizens. The MDH accomplishes this through the agency's goals of:

(1) Assessing health status indicators of the state's population to document each community's health needs and conduct epidemiological and other studies of specific health problems; (2) Developing, promoting, and supporting public policy and strategies that protect the state's citizens from unsanitary conditions related to the environment and that emphasize healthy lifestyles and the prevention of morbidity and mortality associated with disease and illness; and (3) Assuring access to essential health services.

The MDH's Health Services (HS) department, through the Office of Women's Health and the Office of Child/Adolescent Health Services, administers programs that provide services for the three major populations targeted by the MCH Block Grant: women and infants, children and adolescents, and children with special health care needs (CSHCN). Clinical and support services are provided to the target populations through local county health departments and speciality clinics. Services include prenatal and postnatal care, case management for high risk pregnant and postpartum women and infants, well child and sick child care, as well as restorative services for CSHCN. This network allows the MDH to address the needs of children and families, especially those with low incomes, in a family-centered, community-based and coordinated manner that ensures access and availability of quality health care.

The MDH Child Health and Prenatal programs serve all women, infants, and children but target services to women, infants, and children at or below 185 percent of poverty. Services are preventive in nature; however, treatment is often included for those whose need is greatest. Using a multi-disciplinary team approach, including medical, nursing, nutrition and social work, the Child Health Program provides childhood immunizations, well child assessments, limited sick child care, and tracking of infants and other high risk children. Services provided are basically preventive and designed for early identification of disabling conditions. Case management services are provided to high risk pregnant and postpartum women and infants by nurses, social workers and nutritionists. Services are provided in clinic and in the clients home.

In areas where the MDH is not the primary provider of care, the MDH contracts and/or collaborates with private providers to care for the MCH and CSHCN population. Some of these providers conduct regular and/or screening clinics in health department facilities. Others are contracted for consultation and referrals. The MDH provides support services such as case management, nutrition and psychosocial counseling, education and nursing.

In some areas of the state, prenatal patients are seen in health department clinics until delivery and then return to MDH for postpartum and family planning services after delivery. High risk patients are sometimes co-managed by the health department and the private provider.

In other parts of the state, the health department has contractual agreements with private providers whereby the MDH manages the patient until a certain stage of gestation and then transfers the patient to the private provider for the remainder of her care. There are several areas of the state where, when a patient's pregnancy is confirmed, she goes immediately into the private sector or to a community health center or rural health clinic for care.

The number of maternity clients seeking prenatal care at county health departments continues to decline. During FY 1995, the MDH provided maternity services for 22,579 clients, and during FY 2003 only 9,738 clients received maternity services from county health departments. In 2004, according to fiscal year data, 8,383 maternity patients received maternity services from county health departments.

The MDH, in administering the Title V programs, has taken steps to integrate the private medical community into the system through contractual arrangements whereby local physicians provide limited clinical coverage at local health departments. These physicians enhance the continuum of care by becoming the client's provider of after-hours and weekend care when necessary and many times provide a medical home for families as the family's economic status improves.

B. STATE PRIORITIES

Mississippi's health priorities from the 2001 Needs Assessment are enumerated below:

1. Reduce repeat teen births.

2. Improve data collection capacity for Title V population.

3. Explore coverage of asthma services for children.

4. Increase EPSDT screening among children on Medicaid.

5. Reduce the state's low birthweight rate and infant mortality rate.

6. Develop a plan to identify, gather data on, and address issues related to maternal deaths.

7. Decrease cigarette smoking among ninth through twelfth graders.

8. Decrease the incidence of teen mortality and unhealthy behaviors.

9. Assure access to pediatric care for all children, including children with special health care needs.

10. Decrease cigarette smoking among pregnant adolescents.

These state priorities were derived through the needs assessment process in 2000. Priorities were determined based on the needs of the MCH population in relation to current MCH Block Grant state and national measures. The priorities are designed to compliment national performance measures without duplicating any efforts that are currently being used to address the performance measures. Each priority, however, does relate in some way to the state and national performance measures as well as Healthy People 2010 goals.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				99.8	99.6
Annual Indicator	100.0	99.4	100.0	99.9	99.4
Numerator	44075	42039	41511	41295	41219
Denominator	44075	42277	41511	41316	41488
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.7	99.8	99.9	99.9	99.9

Notes - 2004

Denominator is indicative of the genetics data base and the number of infants born in hospitals and screened. Therefore, the number of live births may differ from vital statistics information used in other areas of this report.

a. Last Year's Accomplishments

During CY 2003, 99.9 percent of all newborns in Mississippi received at least one screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies, and Congenital Adrenal Hyperplasia (CAH). In June, 2003, newborn screening was expanded to include forty conditions. All cases of PKU, hypothyroidism, galactosemia, sickle cell disease, and CAH received adequate follow-up which included counseling, medical evaluation, diagnostic services, and treatment.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide screening of all births occurring in the state and follow-up on all inconclusive, adnormal, and presumptive positive results.			**X**	
2. Identify family counseling and arrange for repeat screens for all babies with inconclusive and abnormal results, and arrange for diagnostic evaluations for all babies with presumptive positive results.		**X**		
3. Identify all confirmed cases of genetic disorders detected through the screening process.		**X**		
4. Assure that infants diagnosed with a genetic disorder have a local medical home and are under the care of a physician.		**X**		
5. Continue to assist in coordinating the case management of effected children with local health departments and physicians.		**X**		
6.				
7.				
8.				

9.				
10.				

b. Current Activities

During CY 2004, approximately one hundred percent (99.4) of all newborns in the state received at least one screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies, and Congenital Adrenal Hyperplasia (CAH). In June, 2003, newborn screening was expanded to include forty conditions. In 2003, a total of 105 genetic disorders (74 sickle cell disease, 20 congenital hypothyroidism, 7 galactosemia, 2 cystic fibrosis, 1 biotinidase deficiency, and MCAD) were detected in babies born in Mississippi. Each confirmed case received adequate follow-up, which included counseling, medical evaluation, diagnostic services, and treatment.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to attain 100 percent of all newborns screened and confirmed for genetic disorders. In addition to implementing activities necessary to increase the percent of newborns screened and confirmed, monthly county newborn screening reports will be monitored and evaluated based on the number of positive cases that remain in a system of care for at least 12 months.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective				44.5	47.5
Annual Indicator			41.5	41.5	41.5
Numerator			147	147	147
Denominator			354	354	354
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50.5	53.5	56.5	56.7	56.7

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Last year, program and policy input from CSHCN families included representation on advisory committees where individuals provide input and/or feedback that was both solicited and unsolicited. Parents of CSHCN were and are currently members of the Children's Medical Program Advisory Committee and provide program input.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain family participation through the program advisory committee		X		
2. Maintain CMP Parent Advisory Council		X		
3. Include patient and family subcommittee input in the MCH Block Grant Needs Assessment				X
4. Initiate a contractual program with the Mississippi Cerebral Palsy Foundation				X
5. Utilize a Family Satisfaction Survey tool to obtain information from families regarding the services they receive				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN families currently participate in program and policy development through their participation as members of the Children's Medical Program Advisory Committees throughout the state. The Mississippi Department of Health's Children's Medical Program has a history of families with children with special health care needs providing program and policy input. Program and policy input from CSHCN families has included representation on advisory committees where individuals provide input and/or feedback that is both solicited and unsolicited. Parents of CSHCN are members of the Children's Medical Program Advisory Committee and provide program input along with physicians and other CMP professional and non-professional providers.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to enhance, as well as continue to assure family participation in program policy activities in the State's CSHCN Program. The MSDH's Children's Medical Program (CMP) will continue to work to maintain family participation through the program advisory committee, and include patient and family subcommittee's input in the MCH Block Grant Needs Assessment.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				46.2	48.2
Annual Indicator			44.2	44.2	44.2
Numerator			312	312	312
Denominator			706	706	706
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50.2	52.2	54.2	54.2	54.2

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The SLAITS survey definition of children with special health care needs is much more inclusive than the eligibility criteria for the state's CSHCN program. Efforts are made to ensure that all CMP enrollees receive coordinated, ongoing, and comprehensive care within a medical home. Access to specialty services is facilitated as indicated.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

According to data collected by the SLAITS Survey during the last reporting period, 44.2 percent of Children With Special Health Care Needs (CSHCN)in the Children's Medical Program in Mississippi had a medical home.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include medical home information on CMP applications				X
2. Screen medical home status at all clinic encounters and make referrals as needed	X			
3. Collaborate with primary care physician groups to increase the availability of medical homes				X
4. Continue to coordinate with the University Medical Center to provide care coordination				X
5. Develop CMP case management positions (as funds allow) to provide care coordination services				X
6. Utilize district CMP/Genetics Coordinators to assist in care coordination at the community level				X

7. Collaborate with Coalition of Citizens With Disabilities on Healthy and Ready to Work grant				X
8. Continue to provide continuing education opportunities for primary care providers on topics related to CSHCN				X
9.				
10.				

b. Current Activities

According to data collected by the most recent SLAITS Survey, 44.2 percent of Children With Special Health Care Needs (CSHCN)in the Children's Medical Program in Mississippi had a medical home. This percentage (44.2%)represents no change from the previous year.

c. Plan for the Coming Year

The MDH's Children's Medical Program (CMP) will partner with an organization entitled "Living Independence for Everyone of Mississippi" (LIFE) to implement a transition grant. LIFE has several activities directly related to MCH Children with Special Health Care Needs program efforts in developing access of CSHCN to medical homes.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				54.7	57.7
Annual Indicator			51.7	51.7	51.7
Numerator			370	370	370
Denominator			715	715	715
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60.7	63.7	66.7	66.8	66.8

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance

measure.

a. Last Year's Accomplishments

Last year's data for this measure were captured by the SLAITS Survey and apply to the CSHCN statewide population. The Children's Medical Program makes every effort to help families find insurance coverage.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include insurance information on CMP applications		X		
2. Verify insurance status at all patient encounters and make referrals to other sources		X		
3. Maintain CMP data system				X
4. Continue to work with Medicaid insurers and advocacy groups to promote adequate health coverage for CSHCN				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A national telephone survey of families of children with special health care needs (CSHCN) was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

c. Plan for the Coming Year

A national telephone survey of families of children with special health care needs (CSHCN) was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				70.9	72.9
Annual Indicator			68.8	68.8	68.8
Numerator			245	245	245
Denominator			356	356	356
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74.9	76.9	78.9	78.9	78.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS and differs from the data or percent collected and reported by the state in the narrative for this measure.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

A national telephone survey of families of children with special health care needs (CSHCN) was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provide and coordinate 19 community-based CSHCN subspecialty medical clinics throughout the state				**X**
2. Implement a medical home initiative for CSHCN				**X**
3. Maintain a collaborative relationship with community health centers to provide other needed services				**X**
4. Facilitate communication between specialty and primary care providers through care coordination initiatives				**X**
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

A national telephone survey of families of children with special health care needs (CSHCN) was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to continue its efforts to provide quality services that are accessible to Mississippians who need these services

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				9.8	13.5
Annual Indicator			10.6	10.6	10.6
Numerator			10	10	10
Denominator			94	94	94
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.8	17.8	21.8	21.8	21.8

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

A national telephone survey of families of children with special health care needs (CSHCN) was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement the Healthy and Ready to Work initiative		X		
2. Develop a life-skills clinic for the transition of CSHCN to adulthood		X		
3. Develop a system at Blake Clinic to ensure that transition services are discussed with patients at every opportunity		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A national telephone survey of families of children with special health care needs (CSHCN) was conducted in 2001 to evaluate access to care and services, barriers to care, CSHCN effect on family. The State and Local Area Integrated Telephone Survey (SLAITS) interviews were conducted in Mississippi from October 2000 through April 2002. Overall, Mississippi rates at or above national averages for most categories and questions asked. The survey questions do not specifically match the Block Grant indicators making it difficult to clearly quantify progress and accomplishments.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to continue to support the Children's Medical Program's (CMP) partnership with Living Independence for Everyone of Mississippi an effort to help prepare CSHCN for transition into adulthood.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	84.5	86	87	88	89
Annual Indicator	85.5	85.5	89.9	87.1	87.8
Numerator			803	783	798
Denominator			893	899	909
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90.1	90.2	90.2	90.3

Notes - 2002

These data are generated from a 2 year old survey that does not provide a numerator or denominator.
Percentages, numerators and denominators are derived from a yearly survey conducted by the MDH Immunization department. For example, for the year 2002 MDH surveyed 949 children born in 1999. Out of that we were able to locate and review 893 immunization records. 89.9% of those children were complete at 2 yrs of age.

Notes - 2003

The current Immunization Survey used captures data of children immunized up to 27 months old.
Percentages, numerators and denominators are derived from a yearly survey conducted by the MDH Immunization department. MDH surveyed 955 children born in 2000. Out of that we were able to locate and review 899 immunization records. 87.1% of those children were complete at 2 yrs of age. By sampling the immunization records of 19-35 month olds, the MDH is able to generate immunization rates consistently.

Notes - 2004

Percentages, numerators and denominators are derived from a yearly survey conducted by the MDH Immunization department. MDH surveyed 970 children born in 2001. Out of that we were able to locate and review 909 immunization records. 87.8% of those children were complete at 2 yrs of age. By sampling the immunization records of 19-35 month olds, the MDH is able to generate immunization rates consistently.

a. Last Year's Accomplishments

According to the 2003 immunization survey of children at 27 months of age, 87.1 percent completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B. In 1999, the immunization rate for this age group was 83.9 percent. This survey is conducted annually to obtain statistical estimates of immunization rates of two-year-old children in Mississippi.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to conduct annual immunization surveys to obtain statistical estimates of immunization rate				X
2. Continue to emphasize, through the Statewide Immunization Coalition, immunizations' significance				X
3. Continue to work with the Mississippi Chapter of the American Academy of Pediatrics (AAP)				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

According to the 2004 immunization survey of children at 27 months of age, 87.8 percent completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and hepatitis B.

c. Plan for the Coming Year

The results of the survey of two-year-old children suggests that the state of Mississippi is moving gradually toward achieving the 90 percent national goal. The MSDH will continue to emphasize the significance of completing immunizations by two years of age. Also, professional and public education will continue to be a part of the state effort to increase immunization awareness.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	44	37	37.2	38.2	36.7
Annual Indicator	44.3	38.4	37.7	35.4	35.9
Numerator	2929	2542	2385	2217	2251
Denominator	66165	66165	63321	62706	62706
Is the Data Provisional or				Final	Provisional

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35.3	33.9	32.6	31.3	29.1

Notes - 2003

Annual performance objectives were based on previous five year trend, and, thus, may not appear linear.

a. Last Year's Accomplishments

The 2003 birth rate (per 1,000) for teenagers age 15 through 17 years was 35.4 per 1,000 live births, which represented a slight decrease from CY 2002 rate of 37.7 per 1,000 live births. During FY 2003, approximately 73,000 students attended 1,906 presentations about general and reproductive health. All nine public health districts were active in making presentations to schools.

Collaboration among public health districts continue to take place with community health centers in all medically underserved counties regarding the provision of free contraceptives to teens. Through the EPSDT and Abstinence Programs, children and adolescents 9-18 years of age continue to be counseled regarding postponing sex.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support MDH Statewide Abstinence Education Program				**X**
2. Meet with ministers and church organizations to solicit help in addressing teen pregnancy				**X**
3. Increase collaboration between adolescent pregnancy prevention programs that focus on minorities				**X**
4. Collaborate with community health centers in all medically underserved counties				**X**
5. During postpartum home visits, counsel teens regarding availability of family planning services		**X**		
6. Work with school nurses on counseling teens regarding risky behaviors and goal setting		**X**		
7. Counsel children ages 9-18 regarding postponing sex, reproductive health, and contraception.		**X**		
8. Develop partnerships between the State OB/GYN medical consultants and other providers				**X**
9.				
10.				

b. Current Activities

The 2004 birth rate (per 1,000) for teenagers age 15 through 17 years is 35.9 per 1,000 live births, which represents a slight increase from CY 2003 rate of 35.4 per 1,000 live births. In FY 2004, approximately 75,600 students attended 1,926 presentations about general and reproductive health. All nine public health districts were active in making presentations to

schools.

Collaboration among public health districts will continue to take place with community health centers in all medically underserved counties regarding the provision of free contraceptives to teens. Through the EPSDT and Abstinence Programs, children and adolescents 9-18 years of age will continue to be counseled regarding postponing sex.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue implementing activities aimed at reducing the birth rate for teenagers age 15 through 17 years of age, as well as maintaining collaborative efforts among public health districts and community health centers in all medically underserved counties. Through the EPSDT and Abstinence Programs, counseling will continue to be offered to children and adolescents 9-18 years of age regarding postponing sex.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17	17	17	17	25
Annual Indicator	17	17	17	17	17
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	30	30	30	30

Notes - 2002

A statewide assessment of the presence of sealants among school children was conducted in 1999. This assessment has not been updated.

The annual performance objectives are based on data collected from the Jackson Metropolitan Area and not the entire state.

Notes - 2003

Data for this measure were provided from the latest (1999) Clinical Oral Health Survey.

Notes - 2004

Data for this measure were provided from the latest (1999) Clinical Oral Health Survey.
No numerators and denominators are given due to that information not being released from the agency that originally conducted the oral health survey. This information will be provided in the

future.

a. Last Year's Accomplishments

Since the initiation of the school-based dental sealant program, over 3,700 dental sealants were placed between 2001-2003.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage increased utilization of dental services provided by Medicaid		X		
2. Continue to work with the University School of Nursing and Dentistry to facilitate access to protective sealant services in the Public Health District III area and plan to expand services as resources allow		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Since the initiation of the school-based dental sealant program, over 3,700 dental sealants were placed between 2001-2003. Surveys and screenings are being initiated to monitor sealant progress over future block grant cycles.

c. Plan for the Coming Year

The MDH's Dental Division will continue working to assure that dental providers in Public Health District III continue to screen new second grade classes for dental sealants at each of the participating elementary schools, and place the sealants when indicated. The Dental Division will also continue to develop strategies to expand the Dental Adopt-A-School Program to other public health districts in Mississippi.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	8	9.1	8.6	8.4	8.2

Objective					
Annual Indicator	8.9	8.5	8.9	9.4	8.4
Numerator	53	51	56	56	50
Denominator	598809	598809	631139	595238	595238
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.2	8	7.8	7.6	7.5

Notes - 2002

Annual performance objectives were based on previous five year trend, and, thus, may not appear linear.

a. Last Year's Accomplishments

In Mississippi during CY 2003, the death rate of children aged 1-14 by motor vehicle crashes (per 100,000) was 9.4. This rate has slightly increased from the 2002 rate of 8.9.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with the Safe Kids of Mississippi Coalition to initiate the passage of legislation				**X**
2. Partner with local health departments to provide child safety seats to residents of the state				**X**
3. Develop and implement an initiative to educate and provide information to parents on the proper use of child safety seats		**X**		
4. Utilize educational videos and informational TIPP sheets developed by the Ford Motor Company		**X**		
5. Maintain MDH participation with the Mississippi Association of Highway Safety Coalition				**X**
6. Work with school nurses and other school personnel to promote safety education related to motor vehicle crashes				**X**
7.				
8.				
9.				
10.				

b. Current Activities

Currently, 2004 data indicates that the death rate of children aged 1-14 by motor vehicle crashes (per 100,000) is 8.4. This rate has slightly decreased from the 2003 rate of 9.4. However, provisional data for CY 2004 indicates a decrease at 8.2.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue its collaboration with agencies and

community-based organizations to develop initiatives to decrease death to children age 1-14 caused by motor vehicle crashes.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	48	50	53	55	57
Annual Indicator	48.8	50.4	52.4	45.2	47.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	59	61	63	65	65

Notes - 2003

These data are provided by the most recent "Ross Mother's Survey" periodically sent to a nationally representative sample of new mothers.

Notes - 2004

This measure was estimated based on growth in prior years of reporting. Generally, these data are provided by the most recent "Ross Mother's Survey" periodically sent to a nationally representative sample of new mothers.

Information gathered from the Ross Mother's Survey is given in percentages and numerators and denominators are not available.

a. Last Year's Accomplishments

Last year, according to data from the 2003 Ross Mothers Survey, 45.2 percent of mothers in Mississippi breastfed their infants at hospital discharge, which represented a decrease of at least 7% from 2002. Of these mothers, 19.3 percent continued to breastfeed at 6 months, down from 21.6 percent in 2002. Of the WIC population, 35.6 percent of mothers breastfed their infants at hospital discharge, down from 42.9 percent in 2002. 10.9 percent continued to breastfeed at 6 months, down from 16.9 percent in 2002.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Certify and promote MDH clinics as breastfeeding-friendly facilities		X		
2. Continue the nationally recognized peer counselor breastfeeding program through the MDH		X		
3. Continue the implementation of USDA National Breastfeeding Promotion Campaign		X		
4. Distribute a promotional video to assist WIC clients, physician clinics and hospitals		X		
5. Provide technical training opportunities for health care providers on breastfeeding promotion				X
6. Conduct outreach activities with worksites employing large numbers of women in the childbearing age range		X		
7. Increase collaboration among MDH agency programs and private providers				X
8. Continue to partner with the March of Dimes to encourage providers to apply for funding to provide patient education				X
9.				
10.				

b. Current Activities

Data from the 2004 Ross Mothers Survey revealed that 47.2 percent of mothers in Mississippi breastfed their infants at hospital discharge, which represented an increase of 2 percent from 2003. Of these mothers, approximately 20.2 percent continued to breastfeed at 6 months, up from 19.3 percent in 2003. Of the WIC population, 37.5 percent of mothers breastfed their infants at hospital discharge, up from 35.6 percent in 2003, and 12.2 percent continued to breastfeed at 6 months, up from 10.9 percent in 2003.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to continue implementing initiatives to improve the incidence and duration of breastfeeding among women in Mississippi. These initiatives will include activities such as certifying and promoting MDH clinics as breatsfeeding-friendly facilities, and distributing promotional videos to assist WIC clients, physician clinics and hospitals with ways to address breastfeeding barriers.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	98.5	98.5	98.5	99	99.3
Annual Indicator	94.4	96.0	96.1	96.4	96.7
Numerator	41611	40599	39899	40778	40921

Denominator	44075	42277	41511	42321	42321
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.5	99.6	99.7	99.7	99.8

a. Last Year's Accomplishments

Last year, calendar year (CY) records during 2002 revealed that 39,899 (96.1%) infants have been screened prior to hospital discharge. Extensive training was conducted at all screening facilities to ensure competence of hospital staff in effectively completing the screening procedures and providing timely referral for infants not passing the screening.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Purchase and distribute 60 percent of supplies necessary to carry out universal screening			**X**	
2. Provide technical support to hospitals with regard to the screening process and upgrading equipment				**X**
3. Receive and review written, electronic and faxed reports from birthing hospitals and/or facilities				**X**
4. Review screening reports for risk factors			**X**	
5. Monitor referral of infants to diagnostic centers for confirmation of hearing loss			**X**	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Calendar Year (CY) records for 2003 reveal that 40,778 (96.4%) infants were screened prior to hospital discharge. Provisional data for 2004 indicates that at least 40,921 (98.6%) were screened during CY 2004. Extensive training is being conducted at all screening facilities to ensure competence of hospital staff in effectively completing the screening procedures and providing timely referral for infants not passing the screening.

c. Plan for the Coming Year

Plans for the coming year relevant to this national measure include the upgrading of screening equipment that will improve the accuracy and completeness in the reporting of screening results. Also, the MSDH plans to continue efforts to assure the implementation of universal screening at all hospitals for early detection of hearing impairments in newborns.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	17	14	15	11.5	14.5
Annual Indicator	14.1	15	15	12	10.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10.5	10.4	10.3	10.2	10.1

Notes - 2002

CY 2003 data for this measure were provided from a 2003 report on health status of children in Mississippi published by the Childrens Defense Fund.

Notes - 2003

CY 2003 data for this measure were provided from a 2003 report on health status of children in Mississippi published by the Childrens Defense Fund.

Notes - 2004

Currently, data used to determine the number of children in Mississippi without health insurance are extracted from reports posted by the Children's Defense Fund. Numerators and denominators are unavailable at this point in time.

a. Last Year's Accomplishments

The Division of Medicaid has contracted with the Institutions of Higher Learning to provide a study of the number of uninsured in the state. These data are not currently available but will provide more state specific data on the number of uninsured.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Meet with DFA and Medicaid to discuss alternatives for determining the percent of children without health insurance				**X**
2. Assist DFA and Medicaid in marketing the availability of CHIP to eligible families and/or clients		**X**		
3. Assess health coverage status at every opportunity and provide assistance to families in the completion of applications		**X**		

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, data used to determine the number of children in Mississippi without health insurance is extracted from reports posted by the Children's Defense Fund.

c. Plan for the Coming Year

Mississippi's plan for the coming year relative to this measure is to collaborate with state agencies, advocacy groups, and other projects to identify uninsured children and increase awareness of available health coverage options.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	72	72.5	73	73.5	75
Annual Indicator	72.1	86.5	60.7	92.6	96.7
Numerator	241230	312826	246960	363503	382511
Denominator	334689	361461	406847	392720	395621
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96.8	96.8	97	97.2	97.5

Notes - 2003

Notes - 2004

Data were estimated for this measure because actual 2004 data are unavailable.

a. Last Year's Accomplishments

According to data provided by representatives of the Division of Medicaid, during FY 2003, of the 392,720 potentially Medicaid eligible children age 1-20, (92.6%) 363,503 received a service

paid by the Medicaid program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a Memorandum of Understanding with Medicaid regarding the exchange of data				X
2. Encourage use of out-stationed eligibility workers to assist Medicaid eligible clients		X		
3. Assign local health department staff to assist potentially eligible clients to apply		X		
4. Assess capacity in local health department clinics to increase EPSDT screening				X
5. Identify local resources to improve access and utilization of services for Medicaid and CHIP				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Based on previous data submitted by representatives of the Division of Medicaid, it is estimated that during FY 2004, there were 395,621 potentially Medicaid eligible children age 1-20. Of that number, approximately 382,511 (96.7%) received a service paid by the Medicaid program.

c. Plan for the Coming Year

During the coming year, the MDH plans to continue collaborating with Medicaid to develop a system for data sharing to determine the number of potentially Medicaid eligible children, and to track the number of eligible children receiving a service through the Medicaid program.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	2	2.1	2.2	2.2	2.3
Annual Indicator	2.2	2.1	2.2	2.3	2.3
Numerator	971	882	931	963	963
Denominator					

	44075	42277	41511	42321	42321
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.2	2.2	2.1	2.1	2

Notes - 2003

Notes - 2004

Provisional data based on information from the previous year.

a. Last Year's Accomplishments

Last year, 2.3 percent of all the births in Mississippi were very low birthweight births. This rate represents a slight increase from 2.2 in 2002. Projections indicate that this percent is likely to continue to increase. Implementing the Perinatal High Risk Management/Infant Services System (PHRM/ISS), Pregnancy Risk Assessment Monitoring System (PRAMS) and WIC participation continue to be priorities for Mississippi.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate WIC promotion activities with LBW prevention strategies		X		
2. Work closely with WIC to provide new and continued outreach efforts to potentially eligible women		X		
3. Continue to work with MDH districts to explore the possibility of off-site (out of clinic) WIC certification				X
4. Assess pregnant women for smoking and offer smoking cessation classes and materials		X		
5. Increase participation in PHRM/ISS		X		
6. Track changes in the prevalence of maternal behaviors, attitudes, and experiences				X
7.				
8.				
9.				
10.				

b. Current Activities

During 2004, 2.3 percent of all the births in Mississippi were very low birthweight births. This rate remained at 2.3 percent as reported in 2003. Projections indicate that this percent is likely to continue to increase. Implementing the Perinatal High Risk Management/Infant Services System (PHRM/ISS), Pregnancy Risk Assessment Monitoring System (PRAMS) and WIC participation will continue to be priorities for Mississippi.

c. Plan for the Coming Year

Mississippi's plan for the coming year relative to this measure is to continue implementing

activities targeted at reducing the percent of very low birthweight births. Activities such as working closely with WIC to provide new and continued outreach efforts to potentially eligible populations and assessing pregnant women for smoking and offering smoking cessation classes, materials, and counseling will be implemented.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.9	7.6	7.6	7.6	9.2
Annual Indicator	10.7	7.7	10.9	6.0	8.1
Numerator	25	18	24	13	18
Denominator	233188	233188	219992	216778	222222
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.9	7.7	7.5	7.3	7.1

a. Last Year's Accomplishments

During 2003, the suicide death rate in Mississippi (per 100,000) among youths 15-19 was 6.0, which represents a decrease from the CY 2002 rate of 10.9. Public health and school nurses were available to provide counseling and referral services to youth identified to be at risk by acting as a school and community resource for health education and bridging the communication gaps between adolescents and their families.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Develop strategies for utilization of school health nurses as a school and community resource for health education and to assist in bridging the communication gaps between adolescents and their families				**X**
2. Collaborate with the Department of Mental Health to explore initiatives for preventing suicide deaths among youths, such as suicide risk assessments and prevention				**X**
3. Review records to screen for high risk youth		**X**		
4. Through networks of the Suicide Prevention Coalition, provide information on available resources throughout the state		**X**		

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During 2004, the suicide death rate in Mississippi (per 100,000) among youths 15-19 was 8.1. This represents an increase from the CY 2003 rate of 6.0. Public health and school nurses will continue to be available to provide counseling and referral services to youth identified to be at risk by acting as a school and community resource for health education.

c. Plan for the Coming Year

Mississippi plans to reduce the rate of suicide deaths among youths 15-19 in the coming year by developing strategies for utilization of school health nurses as a school and community resource for health education.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	34.3	34.3	33.2	33	33
Annual Indicator	31.0	33.7	33.2	34.9	33.5
Numerator	301	297	309	336	323
Denominator	971	882	931	963	963
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	34	34.2	34.5	34.8	35

Notes - 2002

Mississippi uses the RNDMU classification of hospitals. The highest level, A, (equivalent to level III) is a teaching hospital with full-time neonatologist, NICU, and both pediatric and obstetrical residency training programs. Level B hospitals cannot be included in the level A category but have a full-time neonatologist, NICU, and =>2 obstetricians.
An additional 34% of very low birth weight infants are born at these level B hospitals.

Notes - 2003

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a. Last Year's Accomplishments

Last year, 34.9 percent of very low birthweight infants were delivered at tertiary centers. The MDH continues to work to develop plans to address perinatal regionalization issues in Mississippi.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to work with the Mississippi Perinatal Association, the Infant Mortality Task Force, and the March of Dimes to evaluate the regionalization system in the state				X
2. Evaluate the current system and develop a plan of improvement if needed				X
3. Continue to conduct annual hospital surveys to obtain status of available manpower for multiple medical services, including maternity and newborn		X		
4. Assess facility availability across the state for perinatal practices and statistics for use in state planning		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During 2004, 33.5 percent of very low birthweight infants were delivered at tertiary centers. This represents a slight decrease from 34.9 percent reported for CY 2003.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this national measure is to increase the percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates by continuing to work with the Mississippi Perinatal Association, the Infant Mortality Task Force, the March of Dimes, and other partners to evaluate the regionalization system in the state.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	81.7	82.7	83.2	84.1	85.1
Annual Indicator	80.8	82.2	83.1	84.3	85.1
Numerator	35634	34760	34501	35663	36015
Denominator	44075	42277	41511	42321	42321
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	87	87.9	88.9	89.9

a. Last Year's Accomplishments

During CY 2003, 84.3 percent of infants born were to women who received prenatal care beginning in the first trimester. This represents a slight increase from 83.1 percent reported for CY 2002.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Medicaid and Department of Human Services to include AFDC checks and Food Stamp mailouts with information on prenatal care, WIC, and family planning		X		
2. Collaborate with Miss. Food Network to distribute information about prenatal care				X
3. Collaborate with the March of Dimes to develop media materials related to early prenatal care				X
4. Collaborate with the Healthy Baby Campaign, a multi-state campaign, to provide coupons for pregnant women who initiate and continue prenatal care				X
5. Collaborate with March of Dimes to implement Stork Nests for clients receiving continuous prenatal care				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During CY 2004, approximately 85.1 percent of infants born were to women who had received prenatal care beginning in the first trimester. This represents a slight increase from 84.3 percent reported for CY 2003.

c. Plan for the Coming Year

Mississippi's plan for this national measure in the coming year is to increase the percent of infants born to pregnant women who received prenatal care beginning in the first trimester by partnering with other agencies and organizations to dissiminate information on the importance of prenatal care, WIC, and family planning.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of Children on Medicaid who Receive EPSDT Screening.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	46%	46	46.5	17	19
Annual Indicator	31.7	13.6	11.9	14.7	15.4
Numerator	106000	32223	32191	38273	40381
Denominator	334689	236562	269555	259836	261831
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	21	23	25	25.5	26

Notes - 2002

The percent of children who received EPSDT screening reported for CY 2001 does not include children under age six. The percent only reflects the number screened age 6-20. This was an effort to determine the number of school age children who are actually screened.

Definition of measure changed in 2001 annual report. Numerator and denominator only included children ages 6-20.

Notes - 2003

These data are provided by the Mississippi Division of Medicaid and are calculated based on the percent of eligibles age 1 to 20 years of age receiving any service. The MDH is making a concerted effort to increase EPSDT screening at local county health departments.

Notes - 2004

These data are estimated based on data from previous reports of the percent of eligibles age 1 to 20 years of age receiving any service.

a. Last Year's Accomplishments

In CY 2003, of the 259,836 Medicaid eligible children (6-20 years old), 38,273 (14.7%) received screening services. The MSDH staff encourged parents who received services through programs such as the Immunization program and/or postpartum home visits to take advantage

of EPSDT screening.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage parents during postpartum home visits to take advantage of EPSDT screenings				X
2. Provide information about EPSDT in WIC Packets		X		
3. Remind parents at immunization visits about the importance of EPSDT and to seek health care		X		
4. Check whether EPSDT screenings are due on children being seen for WIC services and screen if needed				X
5. Develop a plan to provide and ensure EPSDT services to all eligible children in the state				X
6. Conduct mass EPSDT screening in select areas	X			
7. Support funding sources to school nurses to perform EPSDT screening				X
8.				
9.				
10.				

b. Current Activities

During CY 2004, of the 261,831 Medicaid eligible children (6-20 years old), 40,381 (15.4 %) received screening services. The MDH continues to work with the Division of Medicaid, Head Start, and other community partners to increase the EPSDT screening participation rate. Arrangements have been made to provide screening in non-traditional settings and after-hours to facilitate access to services.

c. Plan for the Coming Year

The MDH's plan for the coming year relative to this measure is to continue its efforts to provide increased access to health care for children on Medicaid. The MDH will continue to encourage parents during prenatal care and postpartum home visits to take advantage of EPSDT screenings. Parents will also be provided information about EPSDT screening at immunization visits and in WIC packets. Mass EPSDT screenings will be conducted in selected area of the state as well.

State Performance Measure 2: *Current Percent of Cigarette Smoking Among Ninth Through Twelfth Graders.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	29%	29%	29	22	21
Annual Indicator	32.5	23.6	23.6	25.0	25.0
Numerator	42515	28278	28278	30491	30491
Denominator	130815	119775	119775	122038	122038
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	19	18	18	17.5

Notes - 2002

Drop from 2000-2001 could be associated with programs stemming from the master settlement agreement with tobacco companies.

Notes - 2003

These data were collected and provided by the agency's YRBS Data Survey, which is conducted bi-annually.

a. Last Year's Accomplishments

According to data from the 2003 YRBS Survey, 25 percent of Mississippi's public high school students age 9 through 12 are current smokers. This represents a slight increase from 23.6 in CY 2002.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Through EPSDT, Family Planning and other adolescent visits, counsel youths about tobacco use		**X**		
2. Maintain community-based tobacco prevention programs in collaboration with the Partnership				**X**
3. Maintain use of tobacco prevention curricula in school through the School Health Nurses				**X**
4. Conduct site visits to at least 15 schools to assess tobacco prevention activities				**X**
5. Train staff on smoking cessation specifically targeted to adolescents				**X**
6. Make literature available to communities and schools on smoking cessation		**X**		
7.				
8.				
9.				
10.				

b. Current Activities

According to data from the 2004 YRBS Survey, 25 percent of Mississippi's public high school

students age 9 through 12 are current smokers. Because these data are collected bi-annually, the current percent mentioned above is the same for CY 2003. However, through EPSDT, family planning, and other adolescent visits, the MSDH staff will continue to directly counsel youths concerning the hazards of tobacco use.

c. Plan for the Coming Year

Mississippi's plan for the coming year regarding this measure is to reduce cigarette smoking among 9 through 12 graders. This will be achieved through education and counseling in programs such as EPSDT, Family Planning, maintaining community-based tobacco prevention programs, and collaborating with school health nurses.

State Performance Measure 3: *Smoking Among Pregnant Adolescents*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12	11.5	11.4	11.3	11
Annual Indicator	12.3	12.3	12.5	12.3	12.5
Numerator	1014	929	897	830	846
Denominator	8266	7536	7152	6769	6769
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.6	12.8	12.9	13.1	13.3

a. Last Year's Accomplishments

During CY 2003, 12.3 percent of all pregnant adolescents smoked cigarettes. This represents a slight increase from 12.5 in CY 2002.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with school nurses and health educators to increase school-based health education		X		
2. Continue to educate adolescent pregnant women receiving services on the dangers of prenatal smoking		X		
3. Provide training about smoking cessation and pregnancy to nurses, nutritionists and social workers		X		

4. Refer to PHRM/ISS		X		
5. Refer to Tobacco Quitline Mississippi for information on smoking cessation		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During CY 2004, 12.5 percent of all pregnant adolescents smoked cigarettes. This represents a slight increase from 12.3 in CY 2003. However, in an effort to reduce smoking among pregnant adolescents, the MDH staff continues to work with school nurses and health educators to increase school-based health education classes related to smoking cessation. Pregnant adolescents are also informed and/or provided educational materials as they utilized other MDH services.

c. Plan for the Coming Year

Mississippi's plan for the coming year is to continue its efforts to decrease cigarette smoking among pregnant adolescents by collaborating with school nurses and health educators to increase school-based health education programs related to smoking cessation. The MDH will also continue to educate adolescent pregnant women receiving health department services.

State Performance Measure 4: *Percent of Children With Genetic Disorders who Receive Case Management Services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	95	96	97
Annual Indicator	85.8	94.8	93.7	98.2	99.5
Numerator	2847	4010	2749	3060	2977
Denominator	3320	4228	2935	3117	2992
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98.5	98.5	98.5	98.4

Notes - 2003

The difference in the percent of children with genetic disorders who received case

management services between 2001and 2002, can be attributed to staff changes in the field coupled with the adding of additional screenings mandated by the Mississippi Legislature.

Notes - 2004

During 2004, procedures were installed by the Genetic Services program to ensure that babies who needed a repeat specimen were tested again before they were 6 months old and too old to be screened again. This raised our percentage from 98.2% in 2003 to 99.5% in 2004.

a. Last Year's Accomplishments

During CY 2003, approximately 98.2 percent of children with possible genetic disorders received case management services. All newborn screens with inconclusive, abnormal, or presumptive positive test results were reported to genetics field staff for follow-up. Field staff worked with local health department nurses to contact the families of these babies by phone or home visits to arrange for counseling and case management. They repeated screens or collected diagnostic specimens when needed, and arranged for medical evaluation and treatment or other intervention if indicated. Children diagnosed with genetic disorders received medical care and case management through local physicians, county health departments, the University of Mississippi Medical Center, other treatment centers, and MDH satellite clinics. Case Management services were limited for some infants with inconclusive results at screening due to the inability to locate families or refusal of service by families.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Report all inconclusive, abnormal, and presumptive positive test results to genetics field staff for counseling, clinic appointments, and follow-up.		X		
2. Contact families of babies with inconclusive, abnormal, or presumptive positive test results by phone or home visit, and arrange for counseling or case management.		X		
3. Repeat newborn screens or collect diagnostic specimens as needed, and arrange for medical evaluation and treatment if indicated.		X		
4. Assure that children diagnosed with genetic disorders have a local medical home and are under the care of a physician.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In CY 2004, approximately 99.5 percent of children with possible genetic disorders received case management services. All newborn screens with inconclusive, abnormal, or presumptive positive test results are reported to genetics field staff for follow-up. Field staff work with local health department nurses to contact the families of these babies by phone or home visits to arrange for counseling and case management. They repeat the screens or collect diagnostic specimens if needed, and arrange for medical evaluation and treatment or other intervention if indicated. Children diagnosed with genetic disorders receive medical care and case

management through local physicians, county health departments, the University of Mississippi Medical Center, other treatment centers, and MDH satellite clinics. Case Management services are limited for some infants with inconclusive results at screening due to the inability to locate families or refusal of service by families.

c. Plan for the Coming Year

Mississippi's plan for this measure is to ensure that children testing positive for genetic disorders receive appropriate case management services. This will be acheived by reporting all positive test results to genetic field staff for clinic appointments and follow-up, and conducting home visits on positive cases for case management.

State Performance Measure 5: *Infants Screened and Referred for Hearing Impairment Greater Than or Equal to 35 dB nHL Will Receive Appropriate Follow-up and Intervention Upon Hospital Discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	80	75	80	85
Annual Indicator	81.3	64.3	79.4	96.4	98.4
Numerator	39	257	316	40778	40811
Denominator	48	400	398	42321	41488
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	95	98	98	98.5

Notes - 2002

This indicator changed from 1998 to 1999 creating a drastic difference between these two years. Since then, MSDH has been working on the data system to ensure more accuracy in terms of reporting of tracking and treatment. There have also been discrepancies among providers in terms of what appropriate intervention involves. The overall and the data systems are still developing.

Notes - 2004

Data for this measure was estimated base of past reports.

a. Last Year's Accomplishments

Of the 42,321 screened last year, 96.4 % received appropriate follow-up and intervention upon hospital discharge. Activities were implemented to provide agressive follow-up for those infants being referred from hospital hearing screening processes.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Receive reports on all Mississippi infants who are referred on hospital hearing screening			X	
2. Receive reports on all Mississippi infants who are referred on hospital hearing screening		X		
3. Train hospital staff and audiologists on proper referral procedures				X
4. Develop protocol for follow-up in collaboration with PHRM/ISS, Early Intervention and child health				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During 2004, approximately 98.4 percent of all infants screened received appropriate follow-up. Activities will continue to be implemented to provide agressive follow-up for those infants being referred from hospital hearing screening processes.

c. Plan for the Coming Year

Mississippi's plan for the coming year relevant to this measure is to improve efforts to identify infants who are born with permanent congenital hearing loss by receiving reports on all infants referred on hospital hearing screening, monitoring, and assisting with referred children receiving diagnostic evaluations for confirmation of hearing loss, and training hospital staff and audiologists on proper referral procedures.

State Performance Measure 6: *Prevalence of Infants Born with Neural Tube Defects.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.6	4.7	3	3	4.6
Annual Indicator	5.2	4.7	3.1	2.1	3.9
Numerator	23	20	13	9	16
Denominator	44075	42277	41511	42321	41488

Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3.7	3.7	3.7	3.7	3.7

a. Last Year's Accomplishments

In Calendar Year 2003, of the 42,321 live births in Mississippi, the prevalence of neural tube defects was 2.1 per 10,000 live births. This represents an decrease from 3.1 reported for CY 2002.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Counsel women in family planning clinics regarding the need for the daily consumption of folic acid		**X**		
2. Partner with the March of Dimes to provide education to clinicians statewide				**X**
3. Make folic acid available to the MDH Family Planning population	**X**			
4. Pilot a project in one public health district to provide folic acid education to all women		**X**		
5. Maintain collaboration with the MDH OB/GYN Medical Consultant and March of Dimes				**X**
6. Publish a Mississippi Morbidity Report about Miss. women's folic acid knowledge and behavior				**X**
7. Assess folic acid knowledge and behavior among Mississippi women using PRAMS data.				**X**
8.				
9.				
10.				

b. Current Activities

During CY 2004, of the approximate 41,488 live births in Mississippi, the prevalence of neural tube defects was 3.9 per 10,000 live births, which is slightly higher than the prevalence of 2.1 reported in CY 2003. However, the Mississippi Folic Acid Council organized in April, 2002, continues to meet quarterly regarding educational programs and to discuss ways to increase public awareness of folic acid within Mississippi.

c. Plan for the Coming Year

Mississippi's plan for this measure is to continue to implement initiatives to ensure that women in the reproductive age range consume the appropriate amount of folic acid for improved pregnancy outcome. This will be achieved by continuing to conduct initiatives such as counseling women in family planning clinics regarding the need for the daily consumption of folic acid or a multi-vitamin containing 0.4 mg of folic acid for all women capable of becoming pregnant, partnering with the March of Dimes to provide education to clinicians statewide, and making folic acid available to the MDH Family Planning population that are at high risk of

having an infant with a neural tube defect (NTD).

State Performance Measure 7: *The Rate of Repeat Birth (per 1000) for Adolescents Less Than 18 Years Old.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14.5	13.9	13.6	13.1	13.2
Annual Indicator	150.7	140.6	140.8	138.8	129.1
Numerator	477	385	363	329	306
Denominator	3165	2738	2578	2371	2371
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.5	12	11.6	11.2	10.8

a. Last Year's Accomplishments

During CY 2003, the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 13.9 percent. The MDH sponsored, through MDH's Family Planning Program, collaborative training such as conferences and male involvement workshops, and supports training of MCH/Family Planning nurses to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-pregnancy spacing.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue to sponsor, through MDHs Family Planning Program, collaborative training				**X**
2. Continue to support the training of MCH/Family Planning (MCH/FP) Coordinators				**X**
3. Continue to work with staff to make prevention of repeat adolescent pregnancies a priority				**X**
4. Encourage health departments to provide enhanced family planning services to adolescents				**X**
5. Partner with March of Dimes to implement more Project Alpha Projects				**X**

6. Continue to collaborate with Delta Health Partners (Healthy Start Initiative)				X
7.				
8.				
9.				
10.				

b. Current Activities

During CY 2004, the rate of repeat births per 1,000 female teenagers in Mississippi less than 18 years was 12.9 percent. The MDH will continue to sponsor collaborative training such as conferences and male involvement workshops, and support training of MCH/Family Planning nurses to ensure their understanding of the problem of repeat adolescent pregnancies and the benefits of family planning and inter-pregnancy spacing.

c. Plan for the Coming Year

The MDH will continue to sponsor, through MDH's Family Planning Program, collaborative training such as conferences and male involvement workshops, work with local health department staff to make prevention of repeat adolescent pregnancy a priority in care plans for teen clients, and continue to partner with the Mississippi Chapter of the March of Dimes to implement at least one Project Alpha Program in the state to increase healthy lifestyle behaviors among adolescent males through education and responsible decision-making.

State Performance Measure 8: *The Degree to Which the MCH Program is Developing Data Infrastructure.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			16	16.4	16.8
Annual Indicator		14	16	12	15
Numerator		14	16	12	15
Denominator	16	16	16	16	16
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.2	17.3	17.5	17.6	17.7

Notes - 2002

These scores were developed using a scoring sheet which is available upon request by calling Ulysses Conley at (601) 576-7688.

Notes - 2003

These scores were developed using a scoring sheet which is available upon request by calling Ulysses Conley at (601) 576-7688.

a. Last Year's Accomplishments

Data capacity grew over the past year. As of July 1, 2005, the data unit officially became the Health Services Data Unit (HSDU) and is recognized as an office within the MDH. Dr. Marianne Zotti, CDC MCH Epidemiologist assigned to Mississippi, resigned in February 2005. Despite losing such a valuable member of the Data Team, the HSDU came under the instruction of Lei Zhang, a Business Systems Analyst and biostatisition. Mr. Zhang will recieve his doctorate in Biostatistics in the early fall of 2005. He now directs the HSDU and is helping to expand data infrastructure and capacity. The HSDU now is made up of approximately 12-14 full-time and contract staff.

The HSDU is now responsible for the MCH Block Grant, the State Systems Development Initiative, the Mississippi Asthma program, Closing the Gap on Infant Mortality, and the Youth Risk Behavior Survey. The HSDU partners with all offices within Health Services in order to provide data support to all MCH programs in addition to other public health programs in the MDH.

A preliminary PRAMS report was written in February 2005. However, since the 2002 survey response rate fell below the required 70%, the report was not based on weighted data. In 2003, the PRAMS staff diligently obtained a 73% response rate from the survey and is beginning analysis on the weighted data obtained from CDC.
The CDC/ORISE Fellow completed an analysis of the SLAITS CSHCN dataset. Her findings are included in the needs assessment and are being used to enhance CSHCN services in Mississippi.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to create permanent infrastructure and functions of MCH Data Unit				X
2. Create MCH district performance indicators and develop mechanism for semi-annual reporting				X
3. Create permanent positions to support data functions such as surveillance				X
4. Select and initiate special MCH projects				X
5. Continue to request graduate interns and Fellows to assist with special projects				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Permanent infrastructrure of the data unit has been created and will continue to be sustained by office staff. The HSDU is fully staffed, but seeks two more biostatistician positions in order to

improve analysis capability.
Staff continue to be trained in seeking data and using statistical software. Surveillance is currently a major focus of the data unit. A maternal and infant mortality surveillance system is being created to be used statewide and staff continue to work closely with the SIDS coordinator and PRAMS staff to support their surveillance endeavors. In addition to that, the YRBSS has been added as a project of the HSDU. The HSDU anticipates adding more surveillance activities, such as the Youth Tobacco Survey, to it's roster of projects.
The HSDU continues to accept interns and fellows to work on special analyses and projects. Currently, the MCH/IRC Graduate Student Intern is working to produce a special analysis of 2003 YRBSS data and an executive summary of the 2005 Title V Needs Assessment.
Each item of the plan created from last year's block grant has been either addressed or completed. The progress is as follows:
1. The new OMAP and PRAMS data manager/analyst will complete the MCH Epidemiology certificate graduate program at Emory University. This goal has been revised after reviewing the skills of the OMAP and PRAMS staff. Both have sufficient epidemiology training.
2. Area is being designed to house MCH Data Unit Staff. Completed. Staff are now in one office area.
3. Additional staff from epidemiology and health promotion will be added to the Data Unit. Completed.
4. A Health Program Specialist, Senior will be hired to work with genetics. Completed.
5. The data skills of each member will be assessed and an an annual plan will be designed for each memeber to increase data skills. Completed and ongoing.
6. Additional training will be available about statistical analysis programs. Completed and ongoing.
7. Two conferences related to the needs assessment will be implemented. Completed.
8. A report of PRAMS findings will be developed. Completed. A preliminary report was generated in February 2005.

c. Plan for the Coming Year

Enumerated below are the Health Services Data Unit's plan and strategies to improve data capacity and infrastructure during FY 2006:
1. Begin working with the Office of Child and Adolescent Health to plan the 2005 YRBSS.
2. Hire two research biostatisticians to support the YRBSS, YTS, MCH data, and chronic disease data.
3. Use funding from SSDI to continue and enhance genetics surveillance.
4. The asthma program will be gathering data from all hospitals to determine the prevelance and severity of asthma in Mississippi.
5. The Maternal and Infant Mortality System developed by Closing the Gap staff will be expanded with funding from SSDI. A MIMS report will be generated by Closing the Gap staff based on the findings of the MIMS data from the two Closing the Gap geographical target areas.
6. Data unit staff will use analysis results to publish articles and presentations for journals and conferences.
7. Additional training regarding analysis programs and surveillance will be available.

E. OTHER PROGRAM ACTIVITIES

TORT REFORM
/2004/ In Mississippi, there is increasing concern within the medical community regarding the lack of affordable medical liability Insurance. Currently, the Medical Assurance Company of Mississippi is the only remaining insurance company in Mississippi. It remains primarily because it was established by a group of physicians to assist in providing additional coverage for medical professionals in the state. However, because the Medical Assurance Company of Mississippi has become the sole source of

medical liability insurance, it is impossible for this company to provide coverage for all of the medical professionals in the state. As a result of this, insurance premiums are at a 60% rate increase and expected to rise another 40%. Some medical professionals are considering or have already moved their practices to other states that have affordable insurance premiums.

Until December 31, 2002, Mississippi residents were allowed to sue for any amount of money they deemed commensurate with their loss. There were a number of lawsuits being filed daily and insurance companies had no way of determining the costs they would incur as a result of high claim lawsuits. Insurance companies, fearing that the number of large claims could force them out of business, decided they could no longer afford to provide medical liability coverage in Mississippi.

In the fall of 2002, the Mississippi State Legislature passed a tort claims bill that basically put a cap or limit on the amount of money a person could obtain from a medical lawsuit. The bill became effective January 1, 2003. A cap of $500,000 was signed into law as the maximum amount of money a person could receive. As a result of this bill, thousands of lawsuits were filed December 31, 2002 to avoid the new law. For instance, more than 100 lawsuits were filed in Pike County alone, representing only one of 82 counties. Insurance companies, realizing that it will be years before this legal nightmare is resolved, have not returned to the state.

/2005/ The malpractice climate in this state has changed very little, and it is too soon to determine if recent laws can help resolve this issue. Obstetricians are currently paying premiums on the average of $100,000. //2005//

F. TECHNICAL ASSISTANCE

The MDH is not requesting any technical assistance during this particular grant period.

V. BUDGET NARRATIVE

A. EXPENDITURES

The three components and the anticipated expenditure amounts are described below:

Component A, Services for Pregnant Women and Infants, is budgeted as follows for FY 2006: $3,161,223 for federal funds (30 percent of the total federal award), $2,702,753 for non-federal funds (34 percent of total non-federal funds).

Component B, Services for Child and Adolescent Health, is budgeted as follows for FY 2006: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for non-federal funds (33 percent of total non-federal funds).

Component C, Services for Children with Special Health Care Needs, is budgeted as follows for FY 2006: $3,161,223 for federal funds (30 percent of the total federal award), $2,623,260 for total non-federal funds (33 percent of total non-federal funds).

Administrative Costs are budgeted at $1,053,740 which is 10 percent of the total federal grant award. This amount will not exceed the allowable 10 percent of the total MCH Block Grant as mandated in OBRA 1989.

Personnel are employed to develop and implement standards of care as well as to directly provide services to clients. Typically, classes of employees include physicians, social workers, nurses, nurse practitioners, nutritionists, health aides and clerical staff. Employees are required to meet the standards for practice as specified by his or her professional organization.

Travel is reimbursed for official duty at the state authorized rate of $0.405 per mile. Government contract rates for lodging and per diem ceilings for subsistence are also utilized.

Equipment including minor medical and office, may be purchased in order to administer the program. The equipment items are minor parts of the budget. State regulations governing purchase of equipment are strictly followed.

Supplies include the necessary clinical and office materials to operate the programs and to deliver patient care. Supplies are purchased centrally and according to purchasing policy of state government.

Contractual reflects funds budgeted to purchase services from outside providers. Examples would be for high risk medical care for women and CSHCN.

Construction none.

Other includes telephone, copying and postage used on behalf of the block grant program.

B. BUDGET

The budget for Mississippi's MCH Block Grant application was developed by Health Services in cooperation with the Office of Administrative and Technical Support, Bureau of Finance and Accounts. The total program for FY 2006 is $18,486,681 of which $10,537,408 (57 percent) is Title V and $7,949,273 (43 percent) is match provided in-kind by the applicant. Sources of match funds are state funds, Medicaid earnings (as allowed by the MCH Bureau), and other Third Party earnings. Other federal funds available to support the MCH objectives are listed on Form 4.

The MDH will expend funds for the four types of services (Core Public Health/Infrastructure,

Population Based Individual Services, Enabling and Non-Health Support, and Direct Health Care Services). Services will target the three categories including pregnant women and infants, children and adolescents, and Children with Special Health Care Needs, specifically those in families living at or below 185 percent of the federal poverty level. This includes services to be provided or coordinated for individuals, by category of individual served and source of payment or for budgeting/accounting/auditing for each capacity building activity described in the Annual Plan (e.g., public health leadership and education, assessment, policy development, planning, technical assistance, standard setting, quality assurance, and the like).

Maintenance of Effort: As noted on Form 10, the State Profile, the level of state funds provided for match for FY 2005 is greater than the State's "maintenance of effort" level, i.e., the total amount of State funds expended for maternal and child health program in FY 1989 as indicated in the attached chart.

Matching funds for the MCH Block Grant are identified by listing all direct program costs which have been paid from non-federal sources. These expenses include travel, medicine, medical services, clinical, and lab supplies. Funds used to match Medicaid or other grants are deducted. All salary and non-salary charges for the Children with Special Health Care Needs program are identified by budget. The agency time study provides a report of the value of staff time paid from state or county funds. Time coded to Family Health, Family Planning, Maternity, Perinatal High Risk Management and other Maternal and Child Health efforts are used to match the Perinatal Services category. Time coded to Child Health, Dental Health and School Nurse is used to match the Children and Adolescent category.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.